C.P. v. Blue Cross Blue Shield of Illinois
USDC (W.D. Wash.), No. 3:20-cv-06145-RJB

CONFIDENTIAL EXHIBIT

Filed Under Seal
Pursuant to Protective Order (Dkt. No. 25)

Exhibit A

UNITED STATES DISTRICT COURT

WESTERN DISTRICT OF F WASHINGTON

AT TACOMA

C.P., by and through his parents, Patricia Pritchard and Nolle Pritchard and PATRICIA PRITCHARD,

Plaintiffs,

vs.) No. 3:20-cv-06145-RJB

BLUE CROSS BLUE SHIELD OF ILLINOIS,

Defendant.

ZOOM VIDEO DEPOSITION UPON ORAL EXAMINATION

OF

KIM REED 30(b)(6)

10:13 a.m.

June 2, 2022

REPORTED BY: Pat Lessard, CCR #2104

Are you currently employed?

A. I'm employed by HCSC.

Q. And what's the relationship between HCSC and Blue Cross Blue Shield of Illinois?

A. My understanding is that Blue Cross Blue Shield of Illinois is part of HCSC, which is five different health plans: Blue Cross of Montana, Illinois, New Mexico, Oklahoma, Texas, plus other subsidiary companies as well.

So Blue Cross Blue Shield of Illinois is a part of HCSC.

Q. Thank you. What is your role at HCSC at present?

A. I currently serve as the vice president for medical policy. So that's my title and my role.

Q. What are your responsibilities as vice president for medical policy?

A. So I oversee the development of medical policy at HCSC. I have a team of staff, including nurses and physicians, that are involved in the medical policy development process. So I oversee that process.

We also include physicians from other parts of the company, the various state plans that participate in that as well.

I also oversee the clinical appeals team. So I have a physician that oversees that and he has other physicians on his team that work in that area.

And I also provide clinical support for a variety of other activities, mental health parity, preventative care services, you know, and provide overall clinical support as needed for other initiatives.

Q. Thank you. In your role overseeing the development of medical policy, does that entail clinical research for policy development?

A. Well, when you say "clinical research," we don't do clinical research here.

As part of our medical policy development process we look at and evaluate research that has been done in the medical development process.

Q. What are the types of sources of information that you review in developing medical policy?

A. Well, there's a wide variety of resources that we would use. You know, the foundation for our medical policies is based on the evidence-based clinical literature that's out in the scientific community.

So articles that are published in, you know, respected journals like the New England Journal of

Medicine, the Journal of the American Medical Association. A wide variety of scientific publications.

And we look at resources that we have as being part of the Blue Cross Blue Shield association where we have access to their medical policy resources.

We look at what other personal health plans or government programs are looking at in terms of medical policy.

So there's a broad scope of resources that we use to look at what the current thinking is behind medical policy for certain services, whether it's drugs or devices or procedures or, you know, a whole host of different services.

Q. In what circumstances would HCSC feel the need to develop a medical policy for a particular service?

MS. PAYTON: Object to the form. Object to the form of the question.

Q. (By Mr. Gonzalez-Pagan) Let me restate that.

What is the purpose of a medical policy?

A. Well, fundamentally the medical policy is to give a statement about what our coverage position

would be for a certain service or procedure or device or pharmaceutical.

In general it would not be possible to have a medical policy for every single thing that could possibly be considered as part of a medical service.

But in general we try to develop medical policies for those things or those services where there would be questions from providers or members or whomever in terms of what our coverage position, you know, might be, so that we can provide clarity in terms of those things that we would consider to be medically appropriate, medically necessary, and those things that we would otherwise consider not to be medically necessary.

Q. Thank you. And how long have you been in your current role as the vice president for medical policy?

A. I've been at HCSC for 25 years. As best as I recall, I believe I have -- and I've been in a variety of different roles -- but I believe roughly seven or eight years as overseeing medical policy.

Q. And you mentioned that you have been in other roles prior to that.

Did these roles have to do with the development of medical policy as well?

Blue Shield of Illinois's organizational representative regarding Topic 5.

Are you prepared to testify as to that topic here today?

A. Yes.

Q. Previously we established that Blue Cross Blue Shield of Illinois has a number of medical policies the purpose of which is to provide clarity to providers and members as to what is covered and how on their Blue Cross Blue Shield of Illinois plans, is that correct?

A. Yes.

Q. And then you gave us some testimony about how you review a number of the scientific literature and studies and standards of care in developing these policies, is that correct?

A. Yes.

Q. In developing these policies, these medical policies, do you also consult with specialists in the field with regards to particular aspects of health care?

A. That's frequently part of our process where we would actually reach out to, you know, other specialists within the field or reach out in terms of getting a specialized consultation from various

administration of exogenous endocrine agents to induce feminizing or masculinizing changes, i.e., hormone replacement therapy; gender-affirming or sex-reassignment surgery or procedures and other medical services or preventative medical care provided to treat gender dysphoria and/or related diagnoses as outlined in the World Professional Association for Transgender Health, Standards of Care for the Health of Transsexual, Transgender and Gender nonconforming people, 7th Version."

Do we have the same understanding of what I'm referring to then when I talk about gender-affirming health care?

A. I think so, yes.

Q. Does Blue Cross Blue Shield of Illinois have a medical policy with regards to gender-affirming health care?

A. We have a medical policy that I believe is entitled "Gender Assignment and Gender-Reassignment Surgery," which I think would encompass treatment of individuals who are seeking gender-affirming health care.

MR. GONZALEZ-PAGAN: Thank you. I know we have a couple more minutes left.

I think this might be a good place to stop,

Gender-Assignment Surgery and Gender-Reassignment Surgery with Related Services policy?

A. Well, if we actually look at the policy itself it has a history on it.

I did look at it, you know, within the past couple days. But the specific answer to that would be actually in the policy.

I want to say it's been since around 2008 but I would have to look at the policy to see the history.

Q. Okay.

A. To see how long we've had it.

Q. Well, we'll look at some different variations of the policy over time in a second.

Do you know whether Blue Cross Blue Shield of Illinois had a blanket exclusion for gender-affirming care at one point?

A. Are you saying an exclusion based on the Certificate of Benefits or an exclusion based on medical policy?

Q. Based on medical policy.

A. My understanding is that there was a time, yes, where the policy, if we look at versions of the policy from a number off years ago, that there was a language that indicated that it was not medically

necessary.

Q. Let's take a look at Exhibit 31, if you can, please.

(Marked Deposition Exhibit No. 31.)

MS. PAYTON: Do you want help with that?

THE WITNESS: Let me see. I'm getting it here.

A. Okay. I think I have it.

Q. (By Mr. Gonzalez-Pagan) Do you recognize this document?

A. Yes.

Q. What is it?

A. The document that I have is Gender Assignment Surgery and Gender Reassignment Surgery with Related Services with an effective date of 10/1/2016.

Q. Now previously you indicated that you reviewed some of Plaintiff C.P.'s medical records in preparation for your testimony today, is that right?

A. That's correct.

Q. Would this be the policy that was in effect at the time that Plaintiff C.P. was prescribed a puberty blocker in November of 2016?

A. This would be, based on the date of this policy, October of 2016, I believe it would be the

Q. Were you the VP of medical policy in November of 2015?

A. I would have to pull the records to see. I mean I know that I've been, as I said, roughly around that time, but I would have to look into the documents to see.

Q. Okay. Based on your review of the various medical policies and conversations with some physicians and others at HCSC in preparation for today's deposition do you know when Blue Cross Blue Shield of Illinois decided to cover gender-affirming care under its medical policy?

A. I'm just looking here at the document, looking at the history of it. Because I think that outlines basically the history of how the policy was updated and changed.

It appears, based on what I'm looking at, that it was roughly around 2015.

Q. Okay.

A. Because the document says that document update of literature review, multiple coverage changes from experimental/investigational and/or unproven to medically necessary, primary and secondary gender reassignment surgeries and related terms.

So I believe it would be roughly around that

time in November of 2015 based on the history of the medical policy.

Q. Let's go down two entries on the History, if you don't mind, or the entry dated March 15, 2013.

Do you see that?

A. Yes, I do.

Q. It states "Document updated with literature review. Coverage unchanged. The following was added: Gender reassignment surgery and related services for those members with a contract or a certificate of coverage that would allow for gender reassignment surgery when specific criteria are met."

Does this mean that Blue Cross Blue Shield of Illinois didn't change its policy per se but that it would allow members to override it in 2013, to cover, to allow for coverage?

MS. PAYTON: Object to the form, "Member."

A. So yes. And in relation to your prior question, the update in 2013 would indicate to me that if there were groups, clients, that had decided to have benefits for this type of services that there would be criteria that would be included in terms of determining whether they were medically necessary for those individuals.

Q. (By Mr. Gonzalez-Pagan) Who would set forth

those criteria?

A. The criteria would be set through the Medical Policy Committee.

Q. I'm not trying to be obtuse here. I'm trying to understand.

A. Yes.

Q. There's a medical policy that was established going back to 2006. It didn't allow for coverage.

In 2013 there was a change to allow groups to provide that coverage if certain criteria are met.

Does that mean that the criteria was set by the Medical Policy Committee, if you will -- just to clarify, let me go back, actually, one basic question.

So does this medical policy apply to non-self-funded plans sold or provided by Blue Cross Blue Shield of Illinois?

MS. PAYTON: Object to the form of the question.

A. So my understanding is that this medical policy would apply for insured plans and other self-insured plans that may choose to include coverage under our medical policy.

Q. (By Mr. Gonzalez-Pagan) Okay. Thank you.

Just to clarify the question, then, here.

Does this medical policy apply to insured plans provided by Blue Cross Blue Shield of Illinois?

A. The medical policies that we have in place, yes, typically are applicable to insured plans. I can't speak to whether there may be some exceptions for an insured plan that wants to make some sort of other exception to it.

But in general, yes.

Q. So just to go back and understand the change that occurred in 2013, does this mean that members with self-funded plans could choose to provide coverage in accordance with certain criteria set by the Medical Policy Committee but that that coverage was not available for insured plans in 2013?

MS. PAYTON: Object to the form of the question.

A. I think --

Q. (By Mr. Gonzalez-Pagan) I'm just trying to understand what happened in 2013, right, so.

A. Yeah. So the best of my understanding is that in 2013 the update to the policy was that there were medical criteria that were established that would allow coverage based on clinical criteria for those groups that wanted to include coverage for this condition.

Q. Thank you. And just to clarify when we talk about groups we're talking about self-funded plans, not insured plans?

A. Yes.

Q. Thank you. Okay.

So in 2013 some group members were able to provide coverage in accordance with medical criteria established and then the medical policy was changed in 2015 to apply to not just those group plans that wanted it to but also to insured plans overall, is that correct?

MS. PAYTON: Object to the form.

A. If you can give me a moment. I'm just looking at the language here.

Q. (By Mr. Gonzalez-Pagan) Sure. Take your time.

A. My understanding is that in 2013 the policy was updated so that those groups that chose to provide services for gender reassignment would have coverage available based on clinically based medical criteria.

In 2015, the document to me suggests that there were just updates made to the policy based on clinical criteria.

Q. And the establishment of those medical -- sorry. The establishment of those specific criteria,

was it based on scientific evidence and the review of medical literature?

A. Yes. All of our policies, whether it's this policy or any other medical policy, are based on a review of the scientific literature.

And specifically for this policy to see what those references are they're included in the policy itself to cite which references were reviewed that were the basis for the policy.

Q. What prompted the multiple coverage changes from experimental/investigational and/or unproven to medically necessary in 2015?

MS. PAYTON: Object to the form.

A. Well, my recollection is that -- you know, as a routine process that we had in terms of medical policy development we do at least an annual review of the literature.

And, you know, similar to other policies, the literature changes and there's discussion about what we believe to be appropriate clinical criteria either to approve or not approve coverage for certain procedures.

And I think this was done in a similar fashion where there was a routine update of the policy, consideration of new and emerging literature

and information from various sources.

I do recall that as part of those discussions in around that time there was a review of the WPATH recommendations or guidelines. And WPATH, I'm sure you know, is the World Association of Transgender Health.

So that was considered as well, along with other scientific literature.

Q. (By Mr. Gonzalez-Pagan) Thank you.

Did the passage of the Illinois legislative mandate referenced on the first page of this document have anything to do with the changes to medical policy in 2015?

MS. PAYTON: Object to the form.

A. Well, as I mentioned before, we have a common medical policy across the various states within HCSC. So we don't have different medical policies for Montana or Illinois or New Mexico or any other state because the clinical evidence is what it is.

If there's a legislative mandate or a regulation that lies on top of the medical policy then clearly we would have to adhere to any legislative mandate that was in force for any of the divisions within HCSC.

Q. (By Mr. Gonzalez-Pagan) So because any --

"Psychological services, including but not limited to psychotherapy, social therapy and family counseling and/or

"Chest surgery for FTM individuals."

Did I read that correctly?

A. Yes.

Q. And FTM refers to individuals who are assigned female at birth but identify as male, is that correct?

A. Yes. It's a transition from female to male.

Q. Based on what we just read, the provision of puberty blockers or puberty-suppressing hormones could be considered medically necessary in postdating October 1st, 2016, is that right?

A. Yes.

Q. And based on what we just read, the provision of chest surgery for individuals who are transitioning from female to male could be considered medically necessary even if they are an adolescent?

A. Yes.

Q. Are you familiar with what a Vantas implant is?

A. My understanding is that it's a drug implanted surgically that for individuals who are transitioning in terms of gender can be used as a

puberty blocker.

So it's a type of hormonal therapy.

Q. Under this policy would a Vantas implant be covered as treatment for adolescent gender dysphoria as being medically necessary?

MS. PAYTON: I'll object to the form of the question.

And I just -- I want to put on the record, Omar, I think you know this but I want to make sure it's clear that we have informed you we are not raising a standing affirmative defense in the case.

MR. GONZALEZ-PAGAN: That's understood.

MS. PAYTON: Okay.

MR. GONZALEZ-PAGAN: I will still continue with the line of questioning but I appreciate that.

Thank you.

MS. PAYTON: Okay. So object to the form.

Q. (By Mr. Gonzalez-Pagan) Let me restate my question, Doctor, if you don't mind.

Under this policy, the 2016 policy, under this policy a Vantas implant would have been covered as treatment for adolescent gender dysphoria if deemed medically necessary, correct?

A. Yes, as long as the other criteria within the policy are met.

Recap," do you see that?

A. Yes.

Q. The second sentence reads "Following regulatory Inquiries/requirements, ACA requirements and ALCU (along with others such as GLAAD) involvement, the change policy became effective on 11/6/2015."

Do you see that?

A. I do.

Q. Is it fair to say that -- let me go back.

So any changes to the medical policy are based on scientific review and medical literature.

And you indicated that that included also a review of the WPATH standards of care, is that correct?

A. That's correct.

Q. And was there a discussion also about the nondiscrimination requirements contained in the Affordable Care Act?

A. That was part of the discussion as well, yes.

Q. But ultimately the policy is based on your assessment of the literature and the WPATH standards of care?

A. Yes.

characteristic services being needed to be taken to the 1557 work group for rediscussion.

Is that right?

A. That's what it indicates, yes.

Q. What is the 1557 workgroup?

A. I believe that the 1557 refers to what I think is a federal regulation related to nondiscrimination.

Q. Do you know who was in the Section 1557 workgroup?

A. I'm sorry, I didn't understand that.

Q. Do you know who was on the 1557 workgroup?

A. I believe there were a variety of individuals from the legal and regulatory management area as well as legal counsel and others within HCSC.

Q. Do you know what was the charge of the workgroup?

A. Well, I believe the charge of the workgroup was to make sure that HCSC was in compliance with any regulatory requirements under 1557.

Q. Since the enactment of the Affordable Care Act Section 1557 have all changes to this medical policy gone through the Section 1557 workgroup?

A. I'm so sorry. I didn't catch what you asked.

A. WPATH was a significant consideration in developing the policy.

Q. Thank you. I appreciate that. I guess any question is a little bit different. Let me rephrase it.

Does Blue Cross Blue Shield of Illinois consider care provided in accordance with the WPATH Standards of Care to meet its medical necessity requirements?

MS. PAYTON: Object to the form.

A. To the extent that if you look at our medical policy it is in conformance with current WPATH guidelines and recommendations.

Q. (By Mr. Gonzalez-Pagan) Thank you. Let's turn to -- let me ask you one more question before we move on.

And we can even make reference to Exhibit 31, if you want.

We previously established that Exhibit 31, the 2016 medical policy, would have been the one in effect at the time that Plaintiff C.P. was prescribed a Vantas medical implant in November of 2016, is that correct?

A. Yes.

Q. So the use of a Vantas implant to treat

C.P.'s gender dysphoria would have been covered under the 2016 medical policy, is that correct?

MS. PAYTON: Object to the form.

A. Based on the medical records that I reviewed my opinion is that it would have been eligible for coverage based on the criteria.

Again, I didn't review the record. I didn't, you know, make a decision on that. But based on the records that I reviewed I think it would.

MR. GONZALEZ-PAGAN: Thank you.

If we could turn to Exhibit 33.

(Marked Deposition Exhibit No. 33.)

A. Okay.

Q. (By Mr. Gonzalez-Pagan) It's the Medical Policy -- well, do you recognize this document?

A. Yes, I do.

Q. Okay. And these are the Medical Policy Discussion Conference Call Minutes for February 23rd, 2021, is that correct?

A. Yes.

Q. If we go to the last page of the document.

A. Okay.

Q. On the third bullet point it reads "We have decided as a company to follow WPATH."

Did I read that correctly?

transgender."

Did I read that correctly?

A. Yes.

Q. Does Blue Cross Blue Shield of Illinois agree with that estimate of the population of transgender individuals?

MS. PAYTON: Object to the form.

A. It's a reference from the American Academy of Pediatrics.

I don't think we've taken a position on whether we agree or disagree. It's simply a reference.

Q. (By Mr. Gonzalez-Pagan) Sure. Let me ask that a different way.

Does Blue Cross Blue Shield of Illinois have any reason to dispute those numbers used by the American Academy of Pediatrics?

A. No.

Q. If we can move on to Exhibit 34

(Marked Deposition Exhibit No. 34.) 34.

MS. PAYTON: Thirty-four?

MR. GONZALEZ-PAGAN: Thirty-four, yes.

A. I have it.

Q. (By Mr. Gonzalez-Pagan) Do you recognize this document?

A. Yes.
Q. And this is the same medical policy with an effective date of May 1st, 2019, is that right?
A. Yes.
Q. This is the policy that was in place when the Plaintiff C.P. was provided, prescribed -- let me start over.
This was the policy that was in place when the Plaintiff C.P. was prescribed a second Vantas implant, is that right?
A. I believe so, yes.
Q. And under this policy the provision of that Vantas implant would have been considered medically necessary. Under this policy the provision of that Vantas implant would have been covered if considered medically necessary, is that correct?
A. If it was being covered based on the medical policy, yes.
Q. Just to -- for completeness sake, let's go to the page -- it doesn't have actual numbers, so let's go by the Bates stamp 3369.
A. Okay.
Q. Are you there?
A. Yes.
Q. Okay. In the middle of the page there's a

subsection -- a heading "Gender Reassignment Surgery and Related Services for Children and Adolescents," is that right?

A. Yes.

Q. Okay. And this reads exactly the same as the one we read from 2016, is that correct?

A. I believe so, yes.

Q. It also states that chest surgery for female to male adolescents may be considered medically necessary.

Is that right?

A. That's correct.

Q. And this is the medical policy in effect in the same year that Plaintiff C.P. received chest reconstruction surgery as part of his treatment for general dysphoria.

Is that right?

A. I believe so, yes.

Q. And you reviewed C.P.'s' medical records. Given that he had a referral letter from a mental health provider as well as a doctor to his surgeon for a referral, C.P's chest reconstruction surgery would have been covered as medically necessary under this policy, is that right?

MS. PAYTON: Object to the form.

A. Based on the records that I reviewed and the medical policy, yes, I believe it would have been covered.

MR. GONZALEZ-PAGAN: Let's take a two-minute break.

THE VIDEOGRAPHER: We're going off the record at 1:14 p.m.

(Recess.)

THE VIDEOGRAPHER: We're back on the record at 1:16 p.m.

MR. GONZALEZ-PAGAN: Dr. Reed, I'm just going to refer you to Exhibit 37.

(Marked Deposition Exhibit No. 37.)

A. Exhibit 37?

Q. (By Mr. Gonzalez-Pagan) Yes.

A. Okay. I have it.

Q. This is another version of the gender assignment surgery and gender-reassignment surgery with related services medical policy, is that correct?

A. Yes.

Q. And do you recognize this document?

A. I do.

Q. And if you go to page 18 you see that this document was last updated on January 15, 2021 where it added a couple of references based on the literature

following or finding the sections that are relevant.

Q. (By Mr. Gonzalez-Pagan) And I just want to take you to page two, Note 2 of the document.

And the first sentence reads "Psychotherapy is not required for gender reassignment services except when a mental health professional recommends psychotherapy based on initial assessment prior to gender reassignment surgery."

Did I read that correctly?

A. Yes.

Q. Just to clarify, in order to obtain surgery there's a requirement that there be a referral from a mental health provider but there's no requirement that there be ongoing psychotherapy, is that correct?

MS. PAYTON: Object to the form.

A. I believe that's correct, yes.

Q. (By Mr. Gonzalez-Pagan) Are you aware based Blue Cross Blue Shield -- well, are you aware based on HCSC's medical policies whether Vantas implants are covered for other conditions separate from the treatment for gender dysphoria?

MS. PAYTON: Object to the form, scope.

A. You know, as an emergency medicine physician this isn't an area of my expertise, but I'm generally aware that there could be other indications for this

type of treatment.

MR. GONZALEZ-PAGAN: Okay. I think that's it for us unless there's any redirect.

MS. PAYTON: No redirect. Thank you.

MR. GONZALEZ-PAGAN: Okay. I do want to make a statement on the record just for purposes -- I just want to put on the record that there's a pending motion to compel some documents.

We received some discovery from defendants late last night that we have been unable to review. And given that, you know, we may -- we reserve the ability to recall any of today's 30(b)(6) witnesses, given that there's some late-produced discovery and there's an ongoing motion to compel issue.

But I appreciate your time today, Dr. Reed.

Thank you for you testimony.

MS. PAYTON: Our position for that if is there any unanswered question that -- I don't believe that there is anything pending -- you know, we're here to answer it.

What was produced yesterday was all that privileged stuff that we are agreeing to let you review under the agreement that there is no waiver. It's not really germane to any of this testimony.

And I believe it might have also been --

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Exhibit B

UNITED STATES DISTRICT COURT

WESTERN DISTRICT OF F WASHINGTON

AT TACOMA

C.P., by and through his parents, Patricia Pritchard and Nolle Pritchard and PATRICIA PRITCHARD,

Plaintiffs,

vs.) No. 3:20-cv-06145-RJB

BLUE CROSS BLUE SHIELD OF ILLINOIS,

Defendant.

ZOOM VIDEO DEPOSITION UPON ORAL EXAMINATION

OF

MARK LARSON, 30(b)(6)

8:00 a.m.

June 28, 2022

REPORTED BY: Pat Lessard, CCR #2104

A. Yes.

Q. All right. And so are you aware that you're here to testify on behalf of Blue Cross Blue Shield of Illinois?

A. Yes.

Q. Okay. And you testified already that it's part of HCSC.

So is it okay with you if we use those two terms interchangeably, Blue Cross Blue Shield of Illinois and HCSC?

MS. PAYTON: Object to the form.

A. Yes.

Q. (By Ms. Hamburger) When you're referring to the company do you usually refer to HCSC?

A. Yes.

Q. All right. I'm going to show you -- hopefully you have in front of you Exhibit 1, Plaintiffs' Exhibit 1.

(Referred Deposition Exhibit No. 1.)

MS. PAYTON: Could you remind me what it is?

MS. HAMBURGER: It's the Amended Notice of Deposition.

MS. PAYTON: We have it.

Q. (By Ms. Hamburger) Before we get started, other than the exhibits in this matter do you have any

Q. Did you talk to any people other than your attorneys?

A. No.

Q. Okay. Did you review any transcripts of any other depositions?

A. No.

Q. Okay. You mentioned that your team was involved in the production of some of the documents in this matter.

What were the documents that were produced that your team was involved in?

A. So we produced an Excel document, or I think we turned it into a PDF document that showed Medicare premiums and how we track it from our financial system in a document and the Medicare premiums that we receive from CMS.

We also would have produced that annual statement and also there's another document that we produce that comes from HHS that documented the ACA risk adjustment funds that were by year.

I believe that was it.

Q. Okay. So now I think you testified that all the lines of business of Blue Cross Blue Shield of Illinois are part of HCSC, right?

MS. PAYTON: Object to the form of the

question.

A. Yes. Again, Blue Cross Blue Shield of Illinois is a division of HCSC, yes.

Q. (By Ms. Hamburger) And is that true for the other Blue Cross Blue Shield programs that are part of HCSC?

MS. PAYTON: Object to the form.

A. Yes.

Q. (By Ms. Hamburger) Okay. What are the other state Blue Cross Blue Shield programs that are part of HCSC?

A. We do business as Blue Cross Blue Shield of Texas, Blue Cross Blue Shield of Montana, Blue Cross Blue Shield of New Mexico and Blue Cross Blue Shield of Oklahoma.

Q. Okay. Are there any other d/b/as that Health Care Service Corporation operates under?

MS. PAYTON: Object to the form.

A. No.

Q. (By Ms. Hamburger) And does HCSC do any other business other than health coverage work?

MS. PAYTON: Object to the form.

A. So again, we sell insured health products and uninsured health products.

And then there's also -- I think we have

some long-term care products, so whether you class all that as health.

Q. (By Ms. Hamburger) HCSC is not in the business of selling auto insurance, correct?

A. Correct.

Q. Or homeowners insurance, is that right?

A. Correct.

Q. It focuses on health coverage, is that right?

A. Yes.

Q. Okay. You said you're here to testify about the federal financial assistance received by Blue Cross Blue Shield of Illinois which is topic 6a.

Can you describe the ways in which HCSC or Blue Cross Blue Shield of Illinois receives federal financial assistance?

A. Yes. So we receive federal funds for our insured Medicare products, our insured Medicare Part D products. Also -- I mean not directly from the federal government but Medicaid.

We also have Medicaid contracts that a portion of that would typically be federally funded.

Then we also would receive federal funds as part of our insured ACA product and our ACA small group product.

Q. Just to be clear for the record, when you say "ACA" I'm assuming you mean the Affordable Care Act, is that right?

A. Correct.

Q. So you said the insured ACA individual and small group products?

A. Right.

Q. Anything else?

A. That is it.

Q. Okay. And so let's talk about the Medicare payments, okay?

A. Okay.

Q. Tell me what are those payments? What form do they come in?

A. I'm not sure what you mean by form.

Q. So I think you testified earlier that you get -- that Blue Cross Blue Shield of Illinois or HCSC receives Medicare premium payments from CMS, is that right?

A. That's correct, yes.

Q. Okay. And any other kinds of payments that HCSC receives related to Medicare?

A. Yes. There would be in certain cases and on the product the member could have a premium that they also pay to Blue Cross Blue Shield of Illinois.

Q. Okay. Any other way in which Blue Cross Blue Shield of Illinois or HCSC receives payments related to Medicare from the federal government?

A. No.

Q. Okay. And then let's talk about Medicaid.

You mentioned that indirectly HCSC receives federal financial assistance through Medicaid contracts, is that right?

MS. PAYTON: Object to the form.

A. Yes. Indirectly, yes.

Q. (By Ms. Hamburger) Okay. And is that in the form of premiums or some other kind of payment?

A. So the Medicaid contracts that we have are with the state, so the premium, full premium comes from the state. So it's the state paying Blue Cross Blue Shield of Illinois.

Q. Okay. So the state pays the premium and the funding from the state comes in part from CMS, is that right?

A. That's correct.

Q. Okay. And then for the insured ACA individual payments tell me how those payments are made.

A. They're made from CMS.

Q. From CMS directly to HCSC?

A. Correct.
MS. PAYTON: Object to the form.
A. Correct.
Q. (By Ms. Hamburger) And what are those payments? Are they premium payments?
A. Correct, yes.
Q. And is it fair to say that the CMS payments subsidize the payments made by consumers for the individual market coverage?
A. Ask that again, please.
Q. Yeah. Is it fair to say that the CMS payments in this context subsidize the premium payments made by individual market enrollees?
A. Yes.
Q. This is what's commonly referred to as the Exchange Subsidy, right?
A. Correct, yes.
Q. Okay. And so then in the insured small group products what is that payment?
A. It's the same payment, just from CMS, again for the ACA small group business.
Q. So it's another subsidy?
A. Yes.
Q. And you had mentioned earlier the risk adjustment payment.

Is that -- do you recall mentioning that?

A. Yes.

Q. Okay. Is that separate from the subsidies in the individual and small group markets that HCSC receives?

MS. PAYTON: Object to the form.

A. No. It's all part of that program or part of that product.

Q. (By Ms. Hamburger) Is there any funding for risk adjustments that HCSC receives that's outside of a subsidy for small group and individual market premiums?

MS. PAYTON: Object to the form.

A. No.

Q. (By Ms. Hamburger) All right. I want to turn your attention to section -- oh, wait, let's look at the annual statement.

So I'm going to put on the screen. Exhibit 44. Hold on. It will take a few minutes because it's so big.

(Marked Deposition Exhibit No. 44.)

Q. (By Ms. Hamburger) I'm going to share my screen.

All right. Can you see the annual statement?

Q. Okay. And on page 12360 that's on the screen, this is the attestation about the annual statement, is that right?

MS. PAYTON: Object to the form.

A. Correct.

Q. (By Ms. Hamburger) Okay. Let me just scroll down here.

While I'm doing that, since 2016 has HCSC received Medicare and Medicaid and ACA payments from the federal government?

A. You said since 2016?

Q. Correct.

A. Yes.

Q. Okay. And just to understand here on page 12367 in the annual report for 2019 there's a listing of various lines of business.

Do you see that?

A. Yes.

Q. And it talks about Medicare and Medicaid.

Do you see that?

A. Yes.

Q. Okay. And so that reflects some of the direct business that HCSC has with the federal government, is that right?

A. Correct. Those lines of business.

Q. Okay. And also the federal government, HCSC provides federal employee health benefits, correct?
A. Correct.
Q. Okay. And a Medicare supplement, correct?
A. Correct.
Q. And then here under ten and eleven where it says "Life and Property Casualty" there's no line of business for that, is that right?
A. Correct.
Q. Okay. All right. I want to draw your attention to Exhibit 6.
(Referred Deposition Exhibit No. 6.)
MS. PAYTON: What is that, Ele?
MS. HAMBURGER: That is the assurance.
MS. PAYTON: Got it.
Q. (By Ms. Hamburger) All right. Have you seen Exhibit 6 before?
A. Yes.
Q. Can you tell me what it is?
A. It's an Assurance of Compliance.
Q. And do you know why -- well, is this signed by someone at HCSC?
A. Yes.
Q. Okay. And do you know why this was signed?
A. It's my understanding it's signed as part of

participating in the Affordable Care Act for the ACA individual and small group business.

Q. So it's a condition of participating in the program?

A. Yes.

Q. Okay. And does this signature on behalf of HCSC bind Blue Cross Blue Shield of Illinois?

A. Ask that once more, please.

Q. It's signed by HCSC. Do you understand whether it binds Blue Cross Blue Shield of Illinois?

A. Yes.

Q. And what is your understanding of the promises made in this document?

MS. PAYTON: Object to the form.

A. My understanding is that it's an assurance that we're complying with the items that are listed on there.

Q. (By Ms. Hamburger) Okay. And if HCSC did not sign this assurance would it have been able to participate in the Affordable Care Act Exchange?

MS. PAYTON: Object to the form.

A. I don't know the answer to that.

Q. (By Ms. Hamburger) Okay. Fair enough.

Is it voluntary for the HCSC to participate in the Affordable Care Act Exchange?

A. Yes.
Q. Okay. Are you aware of whether HCSC has a Section 1557 workgroup?
A. I'm not aware.
Q. Okay. Well, let me ask you this. Does HCSC undertake efforts to comply with this assurance in Exhibit 6?
MS. PAYTON: Object to the form.
A. To my knowledge, yes.
MS. HAMBURGER: All right. I want to draw your attention to Exhibit 41.
(Marked Deposition Exhibit No. 41.)
MS. HAMBURGER: That is Blue Cross Blue Shield's answer to the complaint.
MS. PAYTON: Yeah. It's printed out. We have it.
THE WITNESS: I'll take my jacket off here. I'm ready. Thank you for being patient.
MS. HAMBURGER: No problem.
Q. (By Ms. Hamburger) Do you have Exhibit 41 in front of you?
A. Yes.
Q. Can you turn to page 13, paragraph 102.
Okay. Do you see in there that it says Blue Cross Blue Shield is without knowledge that it is

a "covered health program or activity" because, in Paragraph 102, Plaintiffs cite to no legal authority supporting this allegation and Blue Cross Blue Shield of Illinois therefore denies this phrase.

Do you see that?

A. Yes.

Q. And does Blue Cross Blue Shield of Illinois take the position that it is not subject to -- that it is not a covered health program or activity under Section 1557 of the Affordable Care Act?

MS. PAYTON: Object to the form.

A. Ask that again, please.

Q. (By Ms. Hamburger) Yes. Does Blue Cross Blue Shield of Illinois or HCSC take the position that it is not a covered health care program or activity subject to Section 1557 of the Affordable Care Act?

MS. PAYTON: Object to the form of the question.

A. I think for the lines of business for the ACA individual and ACA small group, I mean we are participating in that and that's under Section 1557.

Q. (By Ms. Hamburger) So continue.

A. No, that's it.

Q. So is it your testimony that HCSC and Blue Cross Blue Shield of Illinois is a covered health

program or activity under Section 1557 of the Affordable Care Act because it participates in the ACA individual market and small group markets?

MS. PAYTON: Object to the form.

A. Yeah. Again, I'm not sure what the definition of the covered health program or activity is under that section.

So I mean, again, I'm going to answer -- I mean we are participating, certainly, in the ACA individual and small group that is under Section 1557 of the Affordable Care Act.

Q. (By Ms. Hamburger) And Blue Cross Blue Shield of Illinois and HCSC have pledged in the assurance I showed you earlier to comply with the non-discrimination requirements of the Affordable Care Act, is that right?

MS. PAYTON: Object to the form.

A. Correct.

Q. (By Ms. Hamburger) And then in the last sentence in this paragraph it says "Blue Cross Blue Shield of Illinois denies that its activities as a third-party administrator are subject to Section 1557 of the Affordable Care Act."

Do you see that?

A. Yes.

Q. Is that Blue Cross Blue Shield of Illinois's position?

A. Yes.

Q. And it's that position even though. Blue Cross Blue Shield of Illinois is part of HCSC, is that right?

MS. PAYTON: Object to the form.

A. Yes.

Q. (By Ms. Hamburger) Including its activities as a third-party administrator are part of HCSC?

MS. PAYTON: Object to the form.

A. Yes. It's a line of business. It's another line of business for us.

Q. (By Ms. Hamburger) Okay. It's a line of business that's still part of HCSC, is that right?

MS. PAYTON: Object to the form.

A. Yes.

Q. (By Ms. Hamburger) Do you know the reason why HCSC or Blue Cross Blue Shield of Illinois believes its third-party administration line of business is not subject to Section 1557?

MS. PAYTON: Object to the form of the question.

You can answer but you can't answer anything that you know from legal counsel.

A. Yeah. I can't say I can answer that. And I mean I'm not -- I think that's more of a legal question for our legal area.

Q. (By Ms. Hamburger) Apart from legal advice do you have any knowledge as to why HCSC or Blue Cross Blue Shield of Illinois claims that its third-party administration line of business is not subject to Section 1557?

MS. PAYTON: Object to the form.

Same instruction as the last question.

A. No, I don't.

MS. HAMBURGER: Let's just take a quick break. I think I might be done.

So if you give me five minutes.

THE VIDEOGRAPHER: We're going off the record at 8:38 a.m.

(Recess.)

MS. HAMBURGER: Okay. I don't think I have any more questions.

We can just go back on the record to close it out.

THE VIDEOGRAPHER: One moment, please.

We're back on the record at 8:42 a.m.

MS. HAMBURGER: Thank you, Mr. Larson. I don't have any more questions. I appreciate your time

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USDC (W.D. Wash.), No. 3:20-cv-06145-RJB

CONFIDENTIAL EXHIBIT

Filed Under Seal
Pursuant to Protective Order (Dkt. No. 25)

Exhibit C

DEPARTMENT OF HEALTH AND HUMAN SERVICES

ASSURANCE OF COMPLIANCE

ASSURANCE OF COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, TITLE IX OF THE EDUCATION AMENDMENTS OF 1972, THE AGE DISCRIMINATION ACT OF 1975, AND SECTION 1557 OF THE AFFORDABLE CARE ACT

The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.

2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.

3. Title IX of the Education Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.

4. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.

5. Section 1557 of the Affordable Care Act (Pub. L. 111-148), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 92), to the end that, in accordance with Section 1557 and the Regulation, no person in the United States shall, on the ground of race, color, national origin, sex, age, or disability be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity for which the Applicant receives Federal financial assistance from the Department.

The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property,any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The person whose signature appears below is authorized to sign this assurance and commit the Applicant to the above provisions.

1/3/18
Date

Signature of Authorized Official

Thomas C. Lubben, SVP, Compliance & Privacy officer
Name and Title of Authorized Official (please print or type)

Please mail form to:

U.S. Department of Health & Human Services
Office for Civil Rights
200 Independence Ave., S.W. Room 509F
Washington, D.C. 20201

Health Care Service Corp
Name of Agency Receiving/Requesting Funding

300 E. Randolph St.
Street Address

Chicago IL 60601
City, State, Zip Code

HHS 690 (05/16)

PSC Publishing Services (301) 443-6740 EF

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Filed Under Seal
Pursuant to Protective Order (Dkt. No. 25)

Exhibit D

HCSC Medical Policies

Medical Policies - Surgery

Print

Gender Assignment Surgery and Gender Reassignment Surgery with Related Services

Number: SUR717.001

Effective Date: 10-01-2016

Coverage:

Gender Assignment Surgery

Gender assignment surgery for patients with ambiguous genitalia diagnosed at birth or in infancy **is considered reconstructive surgery and may be considered medically necessary.**

Gender Reassignment Surgery

NOTE: State Legislation may apply. Carefully check for legislative mandates that may apply for each plan.

ILLINOIS Legislative Mandate: 50 Illinois. Administrative. Code 2603.35 provides that a group health insurance plan that is neither a grandfathered plan nor a plan offering excepted benefits shall not discriminate on the basis of an insured's or prospective insured's actual or perceived gender identity, or on the basis that the insured or prospective insured is a transgender person.

Pursuant to the above, Gender Reassignment Surgery would be a covered benefit for Illinois insured policies subject to the coverage criteria set forth below.

CAREFULLY REVIEW the member's benefit contract for gender reassignment surgery and related services provisions.

If there is a discrepancy between this medical policy and the member's benefit contract, the contract will govern.

Gender reassignment surgery -- also known as transsexual surgery or sex reassignment surgery -- and related services **may be considered medically necessary when meeting the criteria for gender dysphoria listed below**.

Otherwise, gender reassignment surgery and related services **will be considered not medically necessary**.

Criteria for Coverage of Gender Reassignment Surgery and Related Services:

The individual being considered for surgery must meet **ALL** the following criteria. The individual **must have**:

- Reached the age of majority; **AND**
- The capacity to make a fully informed decision and to consent for treatment; **AND**
- Been diagnosed with persistent, well-documented gender dysphoria; **AND**
- Referrals for surgery from the individual's qualified mental health professionals (see **NOTE 2** below) competent in the assessment and treatment of gender dysphoria, which include:

1. One referral required for breast/chest surgery that is mastectomy, chest reconstruction, or breast augmentation; **AND**
2. One independent referral required for genital surgery that is hysterectomy, salpingo-oophorectomy, orchiectomy, and/or other genital reconstructive procedures.

NOTE 1: Psychotherapy and Mental Health Services:

Psychotherapy is not required for gender reassignment services except when a mental health professional recommends psychotherapy based on initial assessment prior to gender reassignment surgery. The recommendation for psychotherapy must specify the goals of treatment along with estimates of the frequency and duration of therapy throughout the individual's experience living in one's affirmed gender. Review the criteria above under "Criteria for Coverage of Gender Reassignment Surgery and Related Services" for required surgical referral letters from qualified mental health professionals.

NOTE 2: Two letters of support from mental health professionals for gender reassignment surgery should be submitted. If one letter is from the member's psychotherapist, the second should be from a mental health professional whose only relationship with the member is for evaluation. If the mental health professionals are in the same clinic or group, one letter signed by both is sufficient.

Pharmaceutical Gender Reassignment Services:

Continuous hormone replacement therapy **may be considered medically necessary** prior to gender reassignment of either male-to-female (MtF) or female-to-male (FtM) surgical services **OR** following gender reassignment MtF or FtM surgical services.

Continuous hormone replacement therapy may include the following services:

• Hormone injections by the medical provider, such as during an office visit; and/or

• Self-administered oral and injectables obtained from a pharmacy.

NOTE 3: It is not uncommon for an individual to receive continuous hormone replacement therapy for 12-months or more.

Pharmaceutical agents to treat hair loss or growth, sexual performance post-gender reassignment genital surgery (e.g., Viagra or Cialis), and/or cosmetic enhancements, including collagen and/or botulinum toxin injections, **are considered not medically necessary**.

Related medical policies:

• **RX501.007 - Hormone Replacement Therapies (HRT) Using Implanted Pellets for Women and Delayed Puberty,**

• **RX501.019 - Botulinum Toxin,**

• **RX501.063 - Compounded Drug Products,**

• **RX501.076 - Testosterone Replacement Therapies, and/or**

• **SUR716.001 - Cosmetic and Reconstructive Surgery.**

Gender Reassignment Laboratory Services:

Laboratory testing to monitor continuous hormonal replacement therapy for treatment of gender dysphoria **may be considered medically necessary**.

Primary Sexual Characteristic Gender Reassignment Chest and/or Genital Surgeries:

Male-to-Female (MtF) surgical procedures performed as part of gender reassignment services for an individual who has met the above criteria for gender dysphoria **may be considered medically necessary** and include the following:

• Breast modification, including but not limited to breast enlargement, breast augmentation, mastopexy, implant insertion, and silicone injections, and nipple or areola reconstruction;

• Clitoroplasty;

• Coloproctostomy;

- Colovaginoplasty;
- Labioplasty;
- Orchiectomy;
- Penectomy;
- Penile skin inversion;
- Repair of introitus;
- Vaginoplasty with construction of vagina with graft; and/or
- Vulvoplasty.

Female-to-Male (FtM) surgical procedures performed as part of gender reassignment services for an individual who has met the above criteria for gender dysphoria **may be considered medically necessary** and include the following:

- Hysterectomy;
- Metoidioplasty;
- Phalloplasty;
- Placement of an implantable erectile prostheses;
- Placement of testicular prostheses;
- Salpingo-oophorectomy;
- Scrotoplasty;
- Subcutaneous mastectomy, including nipple or areola reconstruction;
- Vaginectomy (colpectomy);
- Urethroplasty; and/or
- Urethromeatoplasty.

Secondary Sexual Characteristic (Masculinizing or Feminizing) Gender Reassignment Surgeries and Related Services:

Procedures or services to create and maintain gender specific characteristics (masculinization or feminization) as part of the overall desired gender reassignment services treatment plan **may be considered medically necessary for the treatment of gender dysphoria. (See related medical policies below for information regarding related procedures or services because other exclusions may apply)**. These procedures may include the following:

- Abdominoplasty;
- Blepharoplasty (rejuvenation of the eyelid);
- Brow lift;
- Calf implants;
- Cheek implants;
- Chin or nose implants;
- External penile prosthesis (vacuum erection devices);
- Face lift (rhytidectomy);
- Facial bone reconstruction/sculpturing/reduction, includes jaw shortening;
- Forehead lift or conturing;
- Hair removal (may include donor skin sites) or hair transplantation (electrolysis or hairplasty);
- Laryngoplasty;
- Lip reduction or lip enhancement;
- Liposuction/lipofilling or body contouring or modeling of waist, buttocks, hips, and thighs reduction;
- Neck tightening;
- Pectoral implants;
- Reduction thyroid chondroplasty or trachea shaving (reduction of Adam's apple);
- Redundant/excessive skin removal;
- Rhinoplasty (nose correction);
- Skin resurfacing;
- Testicular expanders;
- Voice modification surgery; and/or
- Voice (speech) therapy or voice lessons.

Related medical policies:

- **MED201.030 - Sexual Dysfunctions, Assessment and Treatment,**
- **SUR705.010 - Temporomandibular Joint (TMJ) Disorders (TMJD),**
- **SUR705.030 - Orthognathic Surgery,**

- **SUR707.016 - Varicose Vein Management,**
- **SUR716.001 - Cosmetic and Reconstructive Surgery,**
- **SUR716.003 - Bariatric Surgery,**
- **SUR716.004 - Blepharoplasty, Blepharoptosis, Brow Repair**
- **SUR716.009 - Breast Implant, Removal and/or Insertion,**
- **SUR716.010 - Mastopexy,**
- **SUR716.011 - Reconstructive and Contralateral Mammaplasty,**
- **SUR716.015 - Prophylactic Mastectomy (PM),**
- **SUR716.018 - Chemical Peels,**
- **THE801.027 - Photodynamic Therapy (PDT) for the Treatment of Actinic Keratoses (AK) and Other Skin Lesions,**
- **THE801.028 - Acne Management,**
- **THE801.030 - Nonpharmacologic Treatment of Rosacea, and/or**
- **THE803.014 - Speech Therapy.**

NOTE 4: Preparatory or ancillary procedures (such as anesthesia, tissue harvesting for skin, fat, nerve or muscle grafting, etc.) and supplies or equipment (such as stents, prosthesis, implants, etc.) that are required for the procedures listed above are considered an integral part of the MtF or FtM transition process.

NOTE 5: Surgical repairs or revisions related to MtF or FtM procedures may be required, such as removal and replacement of prostheses.

Gender Reassignment Surgery and Related Services for Children and Adolescents:

The following services **may be considered medically necessary** for the treatment of gender dysphoria for children and adolescents:

- Hormone therapy (such as, puberty-suppressing hormones or masculinizing/feminizing hormones);
- Psychological services, including but not limited to psychotherapy, social therapy, and family counseling; and/or
- Chest surgery for FtM individuals.

NOTE 6: The 2012 World Professional Association for Transgender Health (WPATH) Standards of Care (SOC) (6) state the following regarding adolescent individuals seeking irreversible interventions, such as genital surgery:

"Genital surgery should not be carried out until (i) patients reach the legal age of majority to give consent for medical procedures in a given country, and (ii) patients have lived continuously for at least 12 months in the gender role that is congruent with the gender identity. The age threshold should be seen as a minimum criterion and not an indication in and of itself for active intervention."

Preventive Medicine Gender Reassignment Services:

Preventive medicine services **considered medically necessary in conjunction with gender reassignment services include**:

- Breast cancer screening for FtM individuals; or
- Cervical cancer screening for FtM individuals; or
- Prostate cancer screening for MtF individuals; or
- Contraception pharmaceuticals for FtM individuals at risk of pregnancy.

Related medical policy:

- **ADM1001.030 - Preventive Care Services.**

Gender Reassignment Reproductive Services:

Procurement, cryopreservation/freezing, storage/banking, and thawing of reproductive tissues, such as oocytes, ovaries, embryos, spermatozoa, and testicular tissue **may be considered medically necessary for individuals with gender dysphoria because** gender reassignment services, such as long-term cross-sex hormone therapy or surgical procedures, may render an individual infertile whether or not the individual has reproduced in the past,

Related medical policy:

- **OB402.023 - Reproductive Technologies or Techniques and Related Services.**

Description:

Gender Assignment Surgery

Gender assignment surgery, also known as genitoplasty, is genital reconstruction of ambiguous genitalia in newborns or infants difficult to classify as a male or female. The extent of the ambiguity varies. In very rare instances, the physical appearance may be fully developed as the opposite of the genetic sex (e.g., a genetic male may have developed the appearance of a typical female). (1) To the lay person the determination of an infant's sex can easily be identified as male or female, by virtue of outward genital anatomy, secondary sexual characteristics and behavior within their relevant cultural context. Arriving at a satisfactory scientific definition is more difficult as gender reflects the outcome of complex interactions occurring from the time of conception and extending throughout pre- and postnatal life. (2)

Intersex anomalies associated with ambiguous genitalia may result from major chromosomal abnormalities or from specific gene mutations as in congenital adrenal hyperplasia. (2) Typically, the ambiguous genitalia in genetic females (babies with two X chromosomes) include an enlarged clitoris that has the appearance of a small penis. The urethral opening can be anywhere along, above, or below the surface of the clitoris. The labia may be fused, resembling a scrotum. The infant may be thought to be a male with undescended testicles. Sometimes a lump of tissue is felt within the fused labia, further making it look like a scrotum with testicles. (3, 4)

In a genetic male (babies with one X and one Y chromosome), the ambiguous genitalia typically include a small penis (less than 2-3 centimeters or 0.8-1.2 inches) that may appear to be an enlarged clitoris (the clitoris of a newborn female is normally somewhat enlarged at birth). The urethral opening may be anywhere along, above, or below the penis; it can be placed as low as on the peritoneum, further making the infant appear to be female. There may be a small scrotum with any degree of separation, resembling labia. Undescended testicles commonly accompany ambiguous genitalia. (3, 4)

Disorders which include ambiguous genitalia, which are usually not life threatening, have serious and potentially lifelong consequences for the affected child and, depending on the underlying cause, are likely to entail surgery in childhood and in later life, for example endocrine replacement therapy in conjunction with steroid replacement for those with congenital adrenal hyperplasia. (1) Making a correct determination of gender is both important for treatment purposes, as well as the emotional well-being of the child. Some children born with ambiguous genitalia may have normal internal reproductive organs. However, others may experience health issues from an underlying cause of the disorder. A list of the most common causes is listed below:

- Pseudohermaphroditism, the genitalia are of one sex, but some physical characteristics of the other sex are present.

- True hermaphrodism, a very rare condition in which both ovarian and testicular tissue is present. The child may have parts of both male and female genitalia.

- Mixed gonadal dysgenesis, an intersex condition in which there appears some male structures (gonads, testis), as well as a uterus, vagina, and fallopian tubes.

- Congenital adrenal hyperplasia, a potentially life threatening condition, has several forms, but the most common form causes the genetic female to appear male.

- Chromosomal abnormalities, including Klinefelter's syndrome (XXY) and Turner's syndrome (XO).

• Maternal ingestion of certain medications (including androgenic steroids) may cause a genetic female to look more male.

• Lack of production of specific hormones can cause the embryo to develop with a female body type regardless of genetic sex, such as the lack of testosterone cellular receptors. (1)

Gender Reassignment Surgery

Gender dysphoria (formerly known as 'gender identity disorder') is a condition recognized by the Diagnostic and Statistical Manual (DSM) of Mental Disorders and commonly known as transsexualism. (5) The diagnostic criteria describe many individuals who experience dissonance between their sex at birth and personal gender identity, which is not the same as having ambiguous genitalia.

Gender reassignment surgery is also known as sex reassignment surgery; genital reconstruction surgery; sex affirmation surgery; sex realignment surgery; intersex surgery, or sex-change operation. It is a term used for the culmination of a series of surgical procedures and treatments by which a person's physical appearance and the function(s) of existing sexual characteristics are altered or even irreversibly changed to that of the opposite sex. Gender reassignment generally consists of several treatment plans, which include the diagnostic phase (mostly supported through mental health professional interaction) followed by continuous hormonal therapy (through an endocrinologist). It includes living openly in a manner consistent with the affirmed gender, or completed with the gender reassignment surgery itself. (5)

Other terms are used to describe these procedures. These include sex reconstruction surgery; gender confirmation surgery; feminizing genitoplasty or penectomy, orchidectomy and vaginoplasty for trans women, with masculinizing genitoplasty or phalloplasty for trans men. (Definitions of these procedures can be found later in this Description section.) These procedures and services are used to treat individuals diagnosed with gender dysphoria in transsexual or transgender people. (1, 2, 6)

Guidelines for gender reassignment surgery and related services have been developed by the World Professional Association for Transgender Health (WPATH) (1), formerly known as the Harry Benjamin International Gender Dysphoria Association. WPATH is an international, multispecialty, professional association whose mission is to promote evidence-based care, education, research, advocacy, public policy, and respect for transgender health. In May 2010, WPATH urged de-psychopathologization of gender nonconformity worldwide by stating, "The expression of gender characteristics, including identities, that are not stereotypically associated with one's assigned sex at birth is a common culturally-diverse human phenomenon [that] should not be judged as inherently pathological or negative." WPATH clarified the related

procedures and services when an individual is considering surgical transformation from male-to-female (MtF) or female-to-male (FtM), as well as how the treatment differs for gender dysphoria and transsexualism. (1)

WPATH Standards of Care (SOC)

The WPATH SOC document provides an overview of surgical procedures to treat patients with gender dysphoria. (6)

"For the MtF (male-to-female) patient, surgical procedures may include the following:

1. Breast/chest surgery: augmentation mammoplasty (implants/lipofilling);

2. Genital surgery: penectomy, orchiectomy, vaginoplasty, clitoroplasty, vulvoplasty;

3. Non-genital, non-breast surgical interventions: facial feminization surgery, liposuction, lipofilling, voice surgery, thyroid cartilage reduction, gluteal augmentation (implants/lipofilling), hair reconstruction, and various aesthetic procedures."

"For the FtM (female-to-male) patient, surgical procedures may include to following:

1. Breast/chest surgery: subcutaneous mastectomy, creation of male chest;

2. Genital surgery: hysterectomy/salpingo-oophorectomy, reconstruction of the fixed part of the urethra, which can be combined with a metoidioplasty or with a phalloplasty (employing a pedicle or free vascularized flap), vaginectomy, scrotoplasty, and implantation of erection and/or testicular prostheses;

3. Non-genital, non-breast surgical interventions: voice surgery (rare), liposuction, lipofilling, pectoral implants, and various aesthetic procedures."

SOC criteria for surgical services were introduced as guide to decision making for breast/chest and genital surgery. (6) However, the SOC does not include criteria for other surgical procedures, such as masculinizing or feminizing facial surgery. The SOC does not stipulate the number, sequence, and/or timing of surgical procedures because they will vary from patient to patient, according to an individual patient's clinical needs and expectations, in collaboration with mental health and surgical professionals. (6)

Terminology in Relationship to Gender Reassignment Surgery and Related Services

Health care terminology for transsexual, transgender, and gender nonconforming individuals is rapidly evolving; new terms are being introduced and definitions of existing terms are changing. This tends to create misunderstanding, debate, or disagreement about the language used in this field.

For the purposes of this policy document, we have defined terms that may be unfamiliar or that have specific meanings in the "SOC." Although others may adopt these definitions, WPATH has acknowledged that the terms they use may be defined differently in different cultures, communities, and contexts. (1)

• Bioidentical hormones are structurally identical to those found in the human body and generally derived from plant sources. The hormones used in bioidentical hormone therapy (BHT) need to be commercially processed to become bioidentical. (6)

• Bioidentical compounded hormone therapy (BCHT) are prepared, mixed, assembled, packaged, or labeled as a drug by a pharmacist and custom-made for an individual according to a physician's specifications. (6)

• Cisgender or cissexual describes related types of gender identity perceptions, where the individuals' experiences of their own gender agree with the sex they were assigned at birth. Cisgender may be a complement to transgender. (6)

• Disorders of sex development are the congenital conditions in which the development of chromosomal, gonadal, or anatomic sex is atypical. Some people strongly object to the "disorder" label and instead view these conditions as a matter of diversity (1), preferring the terms intersex and intersexuality.

• Female-to-Male (FtM) describes individuals assigned female at birth who are changing or who have changed their body and/or gender role from birth-assigned female to a more masculine body or role. (6)

• Gender dysphoria, formerly known as gender identity disorder, is characterized by strong persistent cross-gender identification or a discrepancy between with the continuous discomfort or distress about one's anatomic sex (person's sex assigned at birth) or, by a sense of inappropriateness in the gender role of that sex. (1, 2) This includes inappropriateness clinically causes impairment in social, occupational, or other important areas of functioning. (2)

• Gender identity is the intrinsic sense of knowing to which sex one belongs—that is the awareness that 'I am female" (a girl or woman), or "I am male" (a boy or a man). Gender identity is the private experience of gender role and gender role is the public expression of gender identity. Gender role can be defined as everything one says and does, including sexual arousal, to indicate to others or to oneself the degree to which one is male or female. Some individuals describe themselves not as gender-nonconforming, but as unambiguously cross-sexed or unique/transitional. Such individuals no longer consider themselves to be either male or female. An individual may never fully embrace the gender role they were assigned at birth or an individual may actualize their gender identity, role, and expression in a way that does not involve a change from one gender to another gender. (1, 6)

• Gender non-conforming is an adjective to describe individuals whose gender identity, role, or expression differs from what is normative for their assigned sex in a given culture and historical period or the individual differs from the cultural norms prescribed for people of a particular sex. (1)

• Gender role or expression are characteristics in personality, appearance, and behavior that in a given culture and historical period are designated as masculine or feminine (that is, more typical of the male or female social role). While most individuals present socially in clearly masculine or feminine gender roles, some people present in an alternative gender role such as "genderqueer" or specifically transgender. All people tend to incorporate both masculine and feminine characteristics in their gender expression in varying ways and to varying degrees. (1)

• "Genderqueer" is the identity label that may be used by individuals whose gender identity and/or role does not conform to a binary understanding of gender as limited to the categories of man or woman, male or female. (6)

• Genital phenotype is largely determined by androgenic stimulation of the external genitalia in embryonic and fetal life and depends on the presence of the appropriate receptors in the target tissues. (2)

• Gonadal phenotype is defined by the internal genitalia and the external morphology and microanatomy of the gonads (testis or ovary). (2)

• Hormones that express the sexual differentiation in humans include estrogens, progesterone, and androgens, such as testosterone. (6)

• Internalized transphobia describes the discomfort with one's own transgender feelings or identity as a result of internalizing society's normative gender expectations.

• Male-to-Female (MtF) describes individuals assigned male at birth who are changing or who have changed their body and/or gender role from birth-assigned male to a more feminine body or role. (6)

• Natural hormones are derived from natural sources such as plants and animals. Natural hormones may or may not be bioidentical. (6)

• Sex is assigned at birth as male or female, usually based on the appearance of the external genitalia. When the external genitalia are ambiguous, other components of sex (internal genitalia, chromosomal and hormonal sex) are considered in order to assign sex. For most people, gender identity and expression are consistent with their sex assigned at birth; for transsexual, transgender, and gender nonconforming individuals, gender identity or expression differ from their sex assigned at birth. (1)

• Sexual characteristics are the physical and behavioral traits of an organism. In humans, sex organs or primary sexual characteristics are those an individual is born with. These traits are distinguished from secondary sex characteristics that develop later in life usually during puberty. The development of primary and secondary sexual characteristics is controlled by sex hormones produced in the body after the initial fetal stage, dependent on the presence or absence of the Y-chromosome and/or the testis-determining factor/gene to determine development. (6)

• Transgender describes a diverse group of individuals who cross or transcend culturally-defined categories of gender. The gender identity of transgender people differs to varying degrees from the sex they were assigned at birth. (6)

• Transition is the period of time when individuals change from the gender role associated with their sex assigned at birth to a different gender role. For many people, this involves learning how to live socially in another gender role; for others this means finding a gender role and expression that is most comfortable for them. Transition may or may not include feminization or masculinization of the body through hormones or other medical procedures. The nature and duration of transition is variable and individualized. (1, 6)

• Trans men assume male gender identities. Trans men have an internal sense of being male and generally seek to make their maleness known socially and legally along with conforming their primary and secondary sex characteristics to a more typical male appearance. (1)

• Transsexualism is a gender dysphoria disorder in which the person manifests, with constant and persistent conviction, the desire to live as a member of the opposite sex and progressively takes steps to live in the opposite sex role full-time. These individuals who seek to change or who have changed their primary and/or secondary sex characteristics through feminizing or masculinizing medical interventions (hormones and/or surgery), typically accompanied by a permanent change in gender role. (2)

• Transvestism or cross-dressing describes the individual clothing and adopting a gender role presentation that, in a given culture, is more typical of the other sex. (5)

• Trans women assume female gender identities. Trans women have an internal sense of being female and generally seek to make their femaleness known socially and legally along with conforming their primary and secondary sex characteristics to a more typical female appearance. (10)

Definitions of Irreversible Chest and Genital Surgical Procedures for Gender Reassignment

- Augmentation mammaplasty – insertion of breast implants or lipofilling (suctioning of body fat from one body area and filling into another body area) to create the female chest.
- Clitoroplasty – creation of a clitoris, utilizing the penile glans.
- Genitoplasty – genital reconstruction or modification of genitalia.
- Hysterectomy/salpingo-oophorectomy – removal of the uterus with or without ovaries and fallopian tubes.
- Metoidioplasty – following testosterone replacement therapy, the clitoris enlarges to be separated from the labia minora to create a penis.
- Orchiectomy – both testicles are removed.
- Penectomy – removal of the penis.
- Phalloplasty – construction or reconstruction of the penis.
- Reconstruction of the fixed part of the urethra – associated surgical reconstruction with the scrotoplasty to create a scrotal complex.
- Scrotoplasty – creation of a penis from external genitalia, such as the labia majora, with or without testicular prosthesis insertion or implant.
- Subcutaneous mastectomy – removal of breast tissue, sparing the nipple-areola complex to create the male chest.
- Vaginectomy – removal of part or the entire vagina.
- Vaginoplasty – construction or reconstruction of the vaginal canal and may include neovaginoplasty, the partial or total construction of the vulvo-vaginal complex.
- Vulvoplasty – a reduction of the labia and may be known as a labiaplasty.

Rationale:

This policy was originally created in 2006 and has updated regularly with searches of the MedLine database. The most recent literature search was performed through August 2, 2016. The following is a summary of the key literature to date.

Gender Assignment Surgery

The ability to diagnose infants born with intersex conditions has advanced rapidly in recent years. In most cases today, clinicians can promptly make an accurate diagnosis and counsel parents on therapeutic options. However, the paradigm of early gender assignment has been challenged by the results of clinical and basic science research, which show that gender identity

development likely begins in utero. While the techniques of surgical genital reconstruction have been mastered, the understanding of the psychological and social implications of gender assignment is poor. (1-3)

Treatment of ambiguous genitalia is controversial. No one debates the need to treat underlying physiologic problems such as those associated with congenital adrenal hyperplasia or tumors in the gonads. However, treatment for ambiguous genitalia depends on the type of disorder, but will usually include corrective surgery to remove or create reproductive organs appropriate for the gender of the child. Treatment may also include hormone replacement therapy. Controversy revolves around issues of gender assignment by the physician and family which may not correlate with gender preference by the patient in adulthood. (1-4)

For example, Reilly and Woodhouse interviewed and examined 20 patients with the primary diagnosis of micropenis in infancy" and concluded, "[A] small penis does not preclude a normal male role and a micropenis or microphallus alone should not dictate a female gender reassignment in infancy." More particularly, these doctors found that when parents "were well counseled about the diagnosis they reflected an attitude of concern but not anxiety about the problem, and they did not convey anxiety to their children. They were honest and explained problems to the child and encouraged normality in behavior. They believed that this is the attitude that allows these children to approach their peers with confidence. (2-4, 7)

From a medico-legal standpoint, the best approach to managing these cases is to provide parents with as much information as possible so that they can make informed decisions. Adequate counseling and support for parents is vital. The ideal management method is a team approach including neonatologists, geneticists, endocrinologists, surgeons, counselors, and ethicists. (2, 3, 8)

Section Summary: Gender Assignment Surgery

The available evidence supports the conclusion that psychological, medical, and/or surgical services are required for the treatment of ambiguous genitalia; therefore, considered medically necessary.

Gender Reassignment Surgery

Within the past decade, addressing transgender health care concerns has come to the forefront for inclusion and diversity worldwide. (9) These concerns have transcended to all facets of the lesbian, gay, bisexual, or transgender (LGBT) community, including initiating changes in the health care services offered to the transgender individuals.

Clinical Practice Guidelines and Consensus Statements

World Professional Association for Transgender Health (WPATH), formerly the Harry Benjamin International Gender Dysphoria Association, is the most widely recognized standard of practice and have been recognized by national medical

and mental health organizations. (1, 5, 6, 9) WPATH states their overall goal to provide clinical guidance for health professionals to assist transsexuals, transgenders, and gender-nonconforming individuals with safe and effective pathways to achieve lasting personal comfort with their gendered selves, in order to maximize their overall health, psychological well-being, and self-fulfillment. (5)

In the 2012 WPATH Standards of Care (SOC) Seventh Version, clarifies the recommended medically necessary gender reassignment surgery and related services as the following:

"In a June 2008 Clarification Statement, WPATH reiterated the procedures which are considered components of sex reassignment by the Standards of Care and specifically stated that these services are considered medically necessary when clinically indicated. WPATH underscores the clinical significance of the full range of reconstructive interventions including non-genital procedures (e.g., breast augmentation, mastectomy and chest reconstruction, facial feminization surgeries, and facial hair removal).

To ensure treatment effectiveness, WPATH emphasizes that individuals must have access to the procedures which match their clinical needs. Individuals may have a clinical need for specific procedures, although not every individual will require surgery or every possible intervention. Coverage must extend to include the variations which may exist for a given surgery type, and permit a multiple stage surgical process, to ensure clinical appropriateness for the individual." (6, 9)

In November 2015, the International Journal of Transgenderism published recommendations for speech-language therapy for individuals seeking the development of voice and communication that reflects their unique sense of gender. (11) The authors acknowledge the WPATH SOC recognition of speech-language congruency of inner and outer self. Davies et al. expand the speech-language recommendations to include the clinical care by professionals that require trans-specific voice-and-communication assessments, voice feminization protocols-and-voice feminizing surgeries, and voice masculinization protocols. (11)

Section Summary: Gender Reassignment Surgery

The criteria in the 2012 WPATH Seventh Version SOC are supported by evidence-based peer-reviewed scientific literature. Long-term trials of continuous hormonal therapy and living in one's affirmed gender, as well as social support, acceptance by family and peers, contribute to the improvements to the individual's well-being and health, following gender reassignment surgical procedures. Multi-disciplinary mental, medical, surgical, and speech-therapy professionals are crucial towards the best results to match the gender body identity to the intended gender identity role. Therefore,

applicable gender reassignment surgery procedures and related services may be considered medically necessary when meeting the coverage criteria and the member's Benefit Contract allowance for these services.

Contract:

Each benefit plan, summary plan description or contract defines which services are covered, which services are excluded, and which services are subject to dollar caps or other limitations, conditions or exclusions. Members and their providers have the responsibility for consulting the member's benefit plan, summary plan description or contract to determine if there are any exclusions or other benefit limitations applicable to this service or supply. **If there is a discrepancy between a Medical Policy and a member's benefit plan, summary plan description or contract, the benefit plan, summary plan description or contract will govern.**

Coding:

CODING:

Disclaimer for coding information on Medical Policies

Procedure and diagnosis codes on Medical Policy documents are included only as a general reference tool for each policy. **They may not be all-inclusive**.

The presence or absence of procedure, service, supply, device or diagnosis codes in a Medical Policy document has **no** relevance for determination of benefit coverage for members or reimbursement for providers. **Only the written coverage position in a medical policy should be used for such determinations**.

Benefit coverage determinations based on written Medical Policy coverage positions must include review of the member's benefit contract or Summary Plan Description (SPD) for defined coverage versus. non-coverage, benefit exclusions, and benefit limitations such as dollar or duration caps.

CPT/HCPCS/ICD-9/ICD-10 Codes
The following codes may be applicable to this Medical policy and may not be all inclusive.
CPT Codes

11950, 11951, 11952, 11954, 15780, 15781, 15782, 15783, 15786, 15787, 15788, 15789, 15792, 15793, 15820, 15821, 15822, 15823, 15824, 15825, 15826, 15828, 15830, 15832, 15833, 15834, 15835, 15836, 15837, 15838, 15839, 15876, 15877, 15878, 15879, 17380, 19301, 19303, 19304, 19316, 19318, 19324, 19325, 19340, 19342, 19350, 21120, 21121, 21122, 21123, 21125, 21127, 30400, 30410, 30420, 30430, 30435, 30450, 53430, 54125, 54400, 54401, 54405, 54406, 54408, 54410, 54411, 54415, 54416, 54417, 54520, 54660, 54690, 55175, 55180, 55970, 55980, 56625, 56800, 56805, 56810, 57106, 57107, 57110, 57111, 57291, 57292, 57295, 57296, 57335, 57426, 58150, 58180, 58260, 58262, 58275, 58280, 58285, 58290, 58291, 58541, 58542, 58543, 58544, 58550, 58552, 58553, 58554, 58570, 58571, 58572, 58573, 58661, 58720, 90845, 90846, 90847, 90849, 90853, 90863
HCPCS Codes
None
ICD-9 Diagnosis Codes
Refer to the ICD-9-CM manual
ICD-9 Procedure Codes
Refer to the ICD-9-CM manual
ICD-10 Diagnosis Codes
Refer to the ICD-10-CM manual
ICD-10 Procedure Codes
Refer to the ICD-10-CM manual

Medicare Coverage:

The information contained in this section is for informational purposes only. HCSC makes no representation as to the accuracy of this information. It is not to be used for claims adjudication for HCSC Plans.

The Centers for Medicare and Medicaid Services (CMS) does not have a national Medicare coverage position. Coverage may be subject to local carrier discretion.

A national coverage position for Medicare may have been developed since this medical policy document was written. See Medicare's National Coverage at <http://www.cms.hhs.gov>.

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9. Transgender-inclusive Health Care Coverage and the Corporate Equality Index (2012). Prepared by the Human Rights Campaign Foundation. Available at <http://www.wpath.org> (accessed on July 29, 2015).

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Policy History:

Date	Reason
10/1/2016	Document updated with literature review. Coverage unchanged. Speech-language therapy recommendations included in Rationale.

11/6/2015	Document updated with literature review. Multiple coverage changes from experimental, investigational and/or unproven to medically necessary for primary and secondary gender reassignment surgeries and related services. Coverage statements added for those individuals reaching the age of majority. Rationale and References updated and reorganized.
7/1/2014	Document updated with literature review. Coverage unchanged. CPT/HCPCS code(s) updated.
3/15/2013	Document updated with literature review. Coverage unchanged. The following was added: Gender reassignment surgery and related services, for those members with a contract or a certificate of coverage that would allow for gender reassignment surgery, when specific criteria are met. Title changed from Gender Reassignment Surgery to Gender Assignment Surgery and Gender Reassignment Surgery with Related Services. Policy removed from no further review status.
4/1/2008	Policy reviewed without literature review; new review date only. This policy is no longer scheduled for routine literature review and update.
5/1/2006	New medical document

Archived Document(s):

Title:	Effective Date:	End Date:
Gender Assignment Surgery and Gender Reassignment Surgery with Related Services	11-06-2015	09-30-2016
Gender Assignment Surgery (GAS) and Gender Reassignment Surgery (GRS) with Related Services	07-01-2014	11-05-2015
Gender Assignment Surgery (GAS) and Gender Reassignment Surgery (GRS) with Related Services	03-15-2013	06-30-2014
Gender Reassignment Surgery	04-01-2008	03-14-2013
Gender Reassignment Surgery	05-01-2006	03-31-2008

C.P. v. Blue Cross Blue Shield of Illinois
USDC (W.D. Wash.), No. 3:20-cv-06145-RJB

CONFIDENTIAL EXHIBIT

Filed Under Seal
Pursuant to Protective Order (Dkt. No. 25)

Exhibit F

UNITED STATES DISTRICT COURT

WESTERN DISTRICT OF F WASHINGTON

AT TACOMA

C.P., by and through his parents, Patricia Pritchard and Nolle Pritchard and PATRICIA PRITCHARD,

Plaintiffs,

vs.) No. 3:20-cv-06145-RJB

BLUE CROSS BLUE SHIELD OF ILLINOIS,

Defendant.

ZOOM VIDEO DEPOSITION UPON ORAL EXAMINATION

OF

TELISA DRAKE 30(B)(6)

9:30 a.m.

May 13, 2022

REPORTED BY: Pat Lessard, CCR #2104

treatment?

MS. PAYTON: Object to the form.

A. Yes.

Q. (By Ms. Hamburger) So does HCSC in its Blue plans cover gender-affirming care?

MS. PAYTON: Object to the form.

A. Yes. Our medical policy does cover gender affirming care.

Q. (By Ms. Hamburger) Okay. And that's the same for Blue Cross Blue Shield of Illinois, its medical policy covers gender-affirming care, too?

A. Yes.

Q. And is that the policy of HCSC in all five states?

A. Yes.

Q. Okay. And does the policy for covering gender-affirming care apply to puberty blockers?

MS. PAYTON: Object to the form, scope.

A. Yes.

Q. (By Ms. Hamburger) And just for the record do you know what puberty blockers are?

A. Yes.

Q. Can you describe what your understanding of them is?

MS. PAYTON: Object to the form, scope.

But that medical policy has expanded throughout the years so that's why I would have to refer to the document for exact dates.

Q. You've been at Blue Cross Blue Shield of Illinois for more than 20 years, right?

A. Yes, that is correct.

Q. Okay. And during that time has Blue Cross Blue Shield of Illinois always covered gender affirming care?

MS. PAYTON: Object to the form, outside the scope.

A. That I cannot affirm until I look at the actual policy to see how far back it went.

Q. (By Ms. Hamburger) Okay. And the medical policy that you're referring to, is that the guideline used by -- what exactly is this medical policy? How is it used by Blue Cross Blue Shield of Illinois and HCSC?

MS. PAYTON: Object to the form of the question.

A. That question might be better suited to answer by a medical professional, but I can tell you from an operational standpoint we use that medical policy in order to direct members on what criteria is required in order for a service to be covered.

Q. So there could be bells and whistles here and there that are different but for the most part they're the same?

MS. PAYTON: Object to the form.

A. Clients can add or remove any benefits that they wish, but usually standardly they offer the same types of coverage.

Q. (By Ms. Hamburger) Okay. Is there a starting place for the benefit package when a new client comes in?

MS. PAYTON: Object to the form of the question.

A. Yes. So we do have a standard listing of benefits and ask clients whether they would like to include or exclude those benefits.

Q. (By Ms. Hamburger) And where is the standard listing of benefits codified?

MS. PAYTON: Object to the form.

A. Can you clarify that question?

Q. (By Ms. Hamburger) So a new client comes in. Do they get handed a standard ASO plan that has the standard list of benefits from which they can customize?

MS. PAYTON: Object to the form.

A. Normally a client actually gives us what

computerized system where you actually choose a drop-down but then we can also print it out to a PDF.

Q. And is that the -- just a sec -- the Benefit Program Application?

A. Yes.

Q. Okay.

A. No, no. I'm sorry. Let me clarify.

The Benefit Program Application is a different document. This is the Automated Benefit Summary where we do the drop-down for each benefit.

The Benefit Program Application is the financial services.

Q. And were you asked to produce the Automated Benefit Summary for CHI, Common Spirit in this case?

A. Yes.

Q. Okay. All right. So on the services that are standard does Blue Cross Blue Shield then use standard language in the ASO plan?

MS. PAYTON: Object to the form.

A. If the client chooses to use the automated or the standard language, then yes. But they are able to customize that.

MS. HAMBURGER: Okay. So I want to turn to Exhibit 3.

(Marked Deposition Exhibit No. 3.)

Q. (By Ms. Hamburger) Are you familiar with Exhibit 3

A. I am.

Q. Can you say what that is?

A. The Administrative Services Agreement.

Q. And what is that agreement?

A. This is the agreement between the clients and Blue Cross Blue Shield of Illinois that outlines the terms and conditions of the plan.

Q. And is this agreement signed by all of your clients?

A. Yes.

Q. And is it the same agreement for all of your clients?

A. We do start with our standard document but clients are able to customize.

Q. Are there some parts of it that are not customizable?

MS. PAYTON: Object to the form.

A. That would be more of a legal question and they have governance over this.

Q. (By Ms. Hamburger) Okay. And as far as your six clients, do you know of any ways in which this agreement has been customized?

A. In my book every single one of my clients

the drafting of the Summary Plan Descriptions?

MS. PAYTON: Object to the form of the question.

A. So the Summary Plan Descriptions which we refer to as "Benefit Booklets," when we do draft them, are not normally used to draft that document. It's the Automated Benefit Summary where the benefits are listed out.

So I would say it's a very difficult question that I'm not a hundred percent sure of the answer of.

Q. (By Ms. Hamburger) Okay. Does Blue Cross Blue Shield of Illinois have a Standard Summary Plan Description that it uses for ASO contracts when they're asked to write the Summary Plan Description?

A. Yes. Like I said, we call them Benefit Booklets which is a little bit different because it only depicts the medical benefits and the Summary Plan Description usually depicts all the benefits.

But we do have a kind of like an off-the-shelf that we use to begin that process and then customize it based on what those Automated Benefit Summaries suggest what their benefits are and move from there.

Q. Okay. And then late yesterday we got

what I think I thought it was.

MS. HAMBURGER: Okay. No problem.

MS. PAYTON: Because I understand what your question is.

MS. HAMBURGER: Yeah.

MS. PAYTON: And I can speed this up.

MS. HAMBURGER: Let's take a break.

Should I keep this up on the screen?

MS. PAYTON: Yeah. If we're coming back to it might as well.

MS. HAMBURGER: Let's take a quick break.

THE VIDEOGRAPHER: We're going off the record at 10:22 a.m.

(Recess.)

THE VIDEOGRAPHER: Stand by, please.

We're now back on the record at 10:31 a.m.

You may proceed.

Q. (By Ms. Hamburger) So Ms. Drake, before we went off the record I was asking you if Exhibit 40 is a copy of the off-the-shelf ASO plan for large groups.

A. Yes.

Q. And so are there customized parts of this plan or is this straight off-the-shelf?

A. So this particular benefit document is standard language. However, this particular client

has elected, for example, to only cover $3500 for infertility services. So those pieces, for an example, would be customizable.

However, the transgender section of this particular Benefit Program Application is the standard verbiage.

Q. So the only thing you're sure that is standard about this is the language related to gender-affirming care?

MS. PAYTON: Object to the form. Mischaracterizes testimony.

A. Yes. So this particular document is customizable. The dollars are different, the deductible out of the pocket, like I said, the example of infertility.

But the transgender part of it is the standard response because they did elect the standard benefit.

Q. (By Ms. Hamburger) Okay. So when you say they elected the standard benefit, would it be safe to assume that while there might be differences in financial limits the verbiage related to benefits is standard?

A. Yes, ma'am.

Q. All right. And that's beyond the verbiage

would include examples one, two, four, seven and nine.

Would you just take a look at that and see if you confirm that you agree with me those are clearly blanket exclusions?

MS. PAYTON: Object to the form of the question.

A. Yes.

Q. (By Ms. Hamburger) Okay. And how does Blue Cross Blue Shield of Illinois administer the plans with a blanket exclusion?

MS. PAYTON: Object to the form.

A. All services that would fall under this particular benefit would deny once the claim was received.

Q. (By Ms. Hamburger) And how would Blue Cross Blue Shield of Illinois determine whether it falls under that particular exclusion?

A. Again, we would refer back to that medical policy.

Q. So would the diagnosis code that the claim comes in on determine whether it's excluded or not?

A. Yes. It would be diagnosis in combination with the procedure code.

Q. Okay. And so the diagnosis and the procedure code together would determine whether

Blue Cross Blue Shield of Illinois considered it to be gender reassignment?

A. That's correct.

Q. Okay. And Blue Cross Blue Shield of Illinois has a standard process for making that determination?

MS. PAYTON: Object to the form.

A. Can you clarify your question?

Q. (By Ms. Hamburger) Yes. So when Blue Cross Blue Shield is administering the plans that have total blanket exclusions, that first bucket, it makes that determination -- I understand your testimony to be it makes that determination based on a diagnosis and service code, correct?

A. That is correct.

MS. PAYTON: Object to the form.

A. That is correct.

Q. (By Ms. Hamburger) And when administering those plans that have the blanket exclusion Blue Cross Blue Shield of Illinois's standard practice is to look at the diagnosis and service code to determine if it's gender reassignment, and if it is then it is denied, is that right?

MS. PAYTON: Object to the form.

A. That is correct.

Q. (By Ms. Hamburger) That's the standard practice, right?

MS. PAYTON: Object to the form.

A. Yes.

Q. (By Ms. Hamburger) Now, there's another category of exclusions here that say "Services related to Gender Reassignment Surgery" is excluded, right?

A. Yes.

Q. And plans that fall in that category are CHI and example eight, is that right?

A. That is correct.

Q. Okay. And in those plans -- I mean this is kind of a little confusing. In those plans is counseling covered?

MS. PAYTON: Object to the form, scope.

A. Yes.

Q. (By Ms. Hamburger) Would hormonal prescription drugs be covered?

MS. PAYTON: Object to the form, scope.

A. Honestly I can't answer that particular question due to the fact that Common Spirit doesn't have Blue Cross Blue Shield as their pharmacy carrier.

Q. (By Ms. Hamburger) Okay. Fair enough.

Would puberty blockers be covered?

MS. PAYTON: Object to the form, scope.

Are you asking generally or are you asking about Common Spirit?

Q. (By Ms. Hamburger) Under the plans that are in this bucket number two that excludes services related to gender reassignment surgery.

MS. PAYTON: Object to the form, scope.

A. Depending on how those devices are implanted or -- it would depend on if they would require a surgical implantation or how they were actually billed to us.

If they fell under a surgical procedure then they would be denied.

Q. (By Ms. Hamburger) Okay. And so in those plans would top surgery be denied?

MS. PAYTON: Object to the form, scope.

A. Yes.

Q. (By Ms. Hamburger) And bottom surgery or genital surgery, that would be denied, is that right?

MS. PAYTON: Same objection.

A. Yes.

Q. (By Ms. Hamburger) Okay. And why do these plans make a distinction about surgery as opposed to other forms of gender-affirming --

MS. PAYTON: Object to the form.

Q. (By Ms. Hamburger) -- care?

MS. PAYTON: Object to the form, outside of the scope.

A. I would only speculate personal preference of that particular client.

Q. (By Ms. Hamburger) Any other reason?

MS. PAYTON: Same objection.

A. Not that they've expressed to me.

Q. (By Ms. Hamburger) So there's a third category that provides coverage with some limitations like age or financial limitations, is that right?

A. That is accurate.

Q. Okay. And that includes examples number five and number three?

A. And I believe number ten also.

Q. Okay, and number ten. Yes, I missed that one. Thank you.

But in that bucket what is considered gender-affirming -- what Blue Cross Blue Shield of Illinois considers to be gender reassignment surgery is covered, it just has limitations on it, is that right?

A. That is correct.

Q. Okay. And then there's a fourth bucket that I came up with that relates to identifying certain procedures as cosmetic or excluded but generally

blanket exclusions, right? The buckets three and four? Their limitations --

MS. PAYTON: Objection.

Q. (By Ms. Hamburger) -- on age and financial limitations is bucket three. Bucket four is the cosmetic and exclusion of certain procedures?

MS. PAYTON: Object to the form of the question.

A. Yes.

Q. (By Ms. Hamburger) All right. So bucket one we're agreed that is a blanket exclusion of all coverage related to gender reassignment or it could be -- sometimes it's called gender dysphoria, sometimes it's called gender identity disorder, but bucket number one the common practice is all of those plans ask Blue Cross Blue Shield of Illinois to exclude all services related to gender reassignment, is that correct?

MS. PAYTON: Object to the form of the question.

A. Yes.

Q. (By Ms. Hamburger) So bucket number two, the surgery exclusion, right, in that case how does Blue Cross Blue Shield administer it?

MS. PAYTON: Object to the form. Asked and

answered.

A. We refer back to our medical policy to determine what is surgical services and based on the codes that we receive within the claims determine the denials that the member would receive.

Q. (By Ms. Hamburger) So is it fair to say Blue Cross Blue Shield looks at the diagnostic code and the service code to figure out if it's for gender reassignment?

A. Yes, that's accurate.

Q. And then it looks at the service code in particular to figure out if it is related to surgery?

MS. PAYTON: Object to the form.

A. Yes, that is accurate.

Q. (By Ms. Hamburger) And then what happens if it's related to surgery?

MS. PAYTON: Object to the form, scope.

A. The claim is actually denied within our system and the member receives an Explanation of Benefits with that denial.

Q. (By Ms. Hamburger) All right. So claims and plans that are in buckets one and two turn on whether there's a particular diagnostic code associated with gender dysphoria, right?

MS. PAYTON: Object to the form.

A. Yes, that is correct.
Q. (By Ms. Hamburger) And then it may also be impacted on whether it's a service code that's associated with gender dysphoria, right?
A. Yes.
Q. All right. And do you know how the 200 plans identified in Exhibit 21 were identified?
A. They were identified based on the exclusion of gender dysphoria benefit in -- at some point in some category.
Q. Okay. So let's talk a little bit about -- I'm jumping around.
Do you know what percentage of the plans identified in Interrogatory No. 6 fall into bucket number one, blanket exclusions?
MS. PAYTON: Object to the form.
A. I do not.
Q. (By Ms. Hamburger) Do you know what percentage of the identified plans fall into bucket number two, the exclusions related to surgery?
MS. PAYTON: Object to the form.
A. I do not.
Q. (By Ms. Hamburger) Do you know the percentage of the plans that fall into bucket three or four?

MS. PAYTON: Object to the form.
A. I do not.
Q. (By Ms. Hamburger) Do you know what percentages of those plans are secular in each bucket?
MS. PAYTON: Object to the form. Asked and answered.
A. I do not.
MS. HAMBURGER: All right. So let's talk about CHI. I want to turn to Exhibit 12.
(Marked Deposition Exhibit No. 12.)
Q. (By Ms. Hamburger) Do you know what Exhibit 12 is?
A. I do.
Q. Can you tell me what it is?
A. It's the Catholic Health Initiatives Summary Plan Description and it is from 2017.
Q. Okay. And in 2017 was there a specific exclusion of gender-affirming care in the plan?
A. There was not.
Q. Okay. Do you know when --
MS. PAYTON: I think she wants to --
A. Can I clarify my answer?
Q. (By Ms. Hamburger) Sure.
A. It was silent. There was not a call out within their SPD.

Q. Okay. So do you know when the specific express exclusion of gender-affirming care shows up in the CHI plan?

A. In their particular document I believe it was 2019 that we looked at that.

Q. Okay. Well, you know, I'm not trying to trip you up but let's go to Exhibit 13.

(Marked Deposition Exhibit No. 13.)

A. Oh, I apologize. It's 2018.

Q. (By Ms. Hamburger) 2018. It shows up in 2018, right?

A. Yes.

Q. Okay. So before 2018 there was no express exclusion of transgender reassignment surgery in the CHI plan, correct?

A. Correct.

Q. Okay. Were these services covered under the CHI plan before 2018?

A. They were subject to our medical policy until the exclusion came about in 2017.

Q. Okay. So the exclusion came about what year?

A. In our document it was 20 -- let me refer back to the BPA. I'm sorry.

Q. Well, no, I know this is confusing. So I

then we would have our medical director review it or our medical staff based on our medical policy. And that's how the claims would be adjudicated.

However, they do have to take into consideration what the plan covers and what the client's plan excludes.

MS. HAMBURGER: Fair enough.

So let's go to Exhibit 19.

(Marked Deposition Exhibit No. 19.)

Q. (By Ms. Hamburger) Have you seen Exhibit 19 before?

A. I have, yes.

Q. And can you tell me what it is?

A. This is a sampling of the letter that we send out to members when they ask for particular benefits.

And this particular letter notates that the patient was looking for a mastectomy and it's stating that it's a contract exclusion and that there's no benefits available for that procedure.

Q. And this is for the plaintiff in this case, correct, C.P.?

A. Yes. That is correct, yes.

Q. And mastectomies are covered under the CHI plan for cisgender women, is that correct, when

medically necessary?

A. That is correct.

Q. So it's not accurate that mastectomies are excluded always, is that right?

A. That is correct.

Q. This letter was provided because it was a mastectomy to treat gender dysphoria, is that correct?

A. That is correct. That's what qualified that as a contract exclusion was the diagnosis.

Q. Right. It didn't say that in this letter, but that's the reason for the exclusion, the diagnosis, right?

MS. PAYTON: Object to the form.

A. Correct.

MS. HAMBURGER: Okay. Let's look at Exhibit 20, please.

(Marked Deposition Exhibit No. 20.)

Q. (By Ms. Hamburger) Okay. Can you tell me what Exhibit 20 is?

A. This is another letter that was based on a predetermination that we received from a provider for this particular member for the Vantas implant and it also states that it's a contract exclusion.

Q. Okay. And this is for the named plaintiff C.P. in this matter, right?

Which is fine. We've let her do that, but please note that this is way far afield.

Go ahead and answer.

A. I'm sorry. Would you repeat your question?

Q. (By Ms. Hamburger) Yes. The CHI plan will cover Vantas implants when they are provided for a condition that is not gender dysphoria or related to transgender services?

A. As long as --

MS. PAYTON: Let me get the objection in.

The same objection as I had with the previous question.

A. As long as they're medically necessary, yes.

Q. (By Ms. Hamburger) And so when it says "No benefits are available for the procedure" it really means no benefits are available for this procedure when associated with the diagnosis of gender dysphoria, is that right?

MS. PAYTON: I'm going to object to the question. Outside of the scope.

A. Yes. So based on the diagnosis and the procedure code it's not eligible.

MS. PAYTON: Okay. I'd like to take a break for a couple minutes.

MS. HAMBURGER: Sure.

gender-affirming health care, including the CHI plan exclusion, violated the federal antidiscrimination requirements under the Affordable Care Act?

MS. PAYTON: I'm going to object to the form of the question. The same objection as before.

You can answer "Yes" or "No."

A. Yes, legal involvement was made for this particular exclusion for CHI.

Q. (By Ms. Hamburger) Okay. Does Blue Cross Blue Shield of Illinois's insured plans contain an exclusion of coverage for some or all gender-affirming health care?

A. Can you clarify that again? You said fully insured?

Q. Does Blue Cross Blue Shield of Illinois's insured plans contain an exclusion of coverage for some or all gender-affirming healthcare?

A. Fully insured plans do follow our medical policy and would provide coverage for gender reassignment or gender assignment if it sets that medical policy criteria.

Q. Okay. So there is no blanket exclusion of gender-affirming care in Blue Cross Blue Shield's fully insured plans?

A. For self-funded plans, that's correct.

Sorry.

MS. PAYTON: I think we're getting tired.

MS. HAMBURGER: We are.

A. For fully insured plans, yes, there's no blanket exclusion. I apologize.

Q. (By Ms. Hamburger) Okay. The fully insured plans -- I just want to make sure we have it clear.

The fully insured plans administered by Blue Cross Blue Shield of Illinois do not contain an exclusion of gender-affirming care, correct?

A. Yes, that is correct.

Q. Has Blue Cross Blue Shield of Illinois ever sought judicial guidance under ERISA 502a regarding the implementation of an exclusion for gender affirming care?

MS. PAYTON: Object to the form.

You can answer.

A. Not to my knowledge.

Q. (By Ms. Hamburger) But you're answering here not on your own knowledge but on behalf of Blue Cross Blue Shield of Illinois.

So I've got to ask you again. Has Blue Cross Blue Shield of Illinois ever sought judicial guidance under ERISA 502a regarding whether the implementation of an exclusion of coverage for

some or all gender-affirming health care, including the CHI plan's exclusion, violated its fiduciary duties?

This is topic 2.o.

MS. PAYTON: Object to the form.

You can answer.

A. No.

Q. (By Ms. Hamburger) Does Blue Cross Blue Shield continue to allow its ASO plans the choice of covering or excluding gender-affirming care?

MS. PAYTON: Object to the form.

A. Yes.

Q. (By Ms. Hamburger) Does Blue Cross Blue Shield of Illinois intend to stop allowing the ASO plans the choice of covering or excluding gender-affirming care?

MS. PAYTON: Object to the form.

A. No.

MS. HAMBURGER: Can we take five minutes and see where we are?

Take a little break.

THE VIDEOGRAPHER: We're now off the record at 1:50 p.m.

(Recess.)

THE VIDEOGRAPHER: I'm sorry, Ms. Hamburger.

C.P. v. Blue Cross Blue Shield of Illinois
USDC (W.D. Wash.), No. 3:20-cv-06145-RJB

CONFIDENTIAL EXHIBIT

Filed Under Seal
Pursuant to Protective Order (Dkt. No. 25)

Exhibit H

Your Health Care Benefit Program

Yanfeng Automotive Interiors

YFAI PPO 2020
073898

Administered by:

BlueCross BlueShield of Illinois

A message from

Yanfeng Automotive Interiors

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. If you want more information or have any questions about your health care benefits, please contact the Employee Benefits Department.

Sincerely,

Yanfeng Automotive Interiors

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 your policy's fee schedule, usual and customary charge (which is determined by comparing charges for similar services adjusted to the geographical area where the services are performed), or other method as defined by the 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.

THE UTILIZATION REVIEW PROGRAM	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
Individual Deductible	
— Participating Provider	$1,200 per benefit period
— Non-Participating and Non-Administrator Provider	$2,400 per benefit period
Family Deductible	
— Participating Provider	$2,400 per benefit period
— Non-Participating and Non-Administrator Provider	$4,800 per benefit period
Individual Out-of-Pocket Expense Limit **(does not apply to all services)**	
— Participating Provider	$4,000 per benefit period
— Non-Administrator Provider	No limit
Family Out-of-Pocket Expense Limit	
— Participating Provider	$8,000 per benefit period
— Non-Administrator Provider	No limit
Chiropractic and Osteopathic Manipulation Benefit Maximum	25 visits per benefit period
Physical Therapy Services Benefit Maximum	30 visits per benefit period
Temporomandibular Joint Dysfunction and Related Disorders Benefit Maximum	$1,000 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
— Coordinated Home Care Program	80% of the Eligible Charge
— Outpatient Covered Services	60% of the Eligible Charge
Payment level for Covered Services from a **Non-Administrator Provider**	100% 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	$150 Copayment (waived if admitted to the Hospital as an Inpatient immediately following emergency treatment)
BLUE DISTINCTION/ BLUE DISTINCTION PLUS	
Transplants	
— Blue Distinction Designated Center	80% of the Eligible Charge

— Blue Distinction Plus Designated Center	80% of the Eligible Charge
— Participating Provider	No Coverage
— Non-Participating Provider	No Coverage
Bariatric Surgery	
— Blue Distinction Designated Center	80% of the Eligible Charge
— Participating Provider	No Coverage
— Non-Participating Provider	No Coverage
PHYSICIAN BENEFITS	
Payment level for Surgical/ Medical Covered Services	
— **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
PRESCRIPTION DRUG PROGRAM BENEFITS	
Payment Level	
— Tier 1 Generic Drugs and generic diabetic supplies	$10 per prescription
— Tier 2 Preferred Brand Name Drugs and preferred brand name diabetic supplies	75% of the Eligible Charge per prescription
Minimum	$20 Copay
Maximum	$150 Copay

— Tier 3 Non-Preferred Brand Name Drugs and non-preferred brand name diabetic supplies for which there is no generic available	60% of the Eligible Charge per prescription
Minimum	$45
Maximum	$150

— If your Physician indicates dispense as written on the prescription, you will be responsible for the Copayment/Coinsurance Amount specified above and the following provision will not apply.

— Tier 3 Non-Preferred Brand Name Drugs and non-preferred brand name diabetic supplies for which there is a generic available	60% of the Eligible Charge, minus the difference between the Generic and Brand Name Drugs costs per prescription
— Tier 4 Specialty Drugs	60% of the Eligible Charge
Lancets and Lancet Devices	100% of the Eligible Charge per prescription
Maximum Copayment	
— Tier 2 Preferred Brand Name Drugs	$150 per prescription
— Tier 3 Non-Preferred Brand Name Drugs	$150 per prescription
— Tier 4 Specialty Drug	$150 per prescription
Minimum Copayment	
— Tier 2 Preferred Brand Name Drugs	$25 per prescription
— Tier 3 Non-Preferred Brand Name Drugs	$50 per prescription
— Tier 4 Specialty Drug	$50 per prescription

Non-Participating Pharmacy	
Payment Level	
— Tier 1 Generic Drugs and generic diabetic supplies	60% of the Eligible Charge per prescription
— Tier 2 Preferred Brand Name Drugs and preferred brand name diabetic supplies per prescription	60% of the Eligible Charge
— Tier 3 Non-Preferred Brand Name Drugs and non-preferred brand name diabetic supplies for which there is no generic available	60% of the Eligible Charge per prescription
— If your Physician indicates dispense as written on the prescription, you will be responsible for the Copayment/Coinsurance Amount specified above and the following provision will not apply.	
— Tier 3 Non-Preferred Brand Name Drugs and non-preferred brand name diabetic supplies for which there is a generic available	60% of the Eligible Charge, minus the difference between the Generic and Brand Name Drugs costs per prescription
— Tier 4 Specialty Drugs	60% of the Eligible Charge
Lancets and Lancet Devices	100% of the Eligible Charge per prescription
Maximum Coinsurance	
— Tier 1 Generic Drugs	$200 per prescription
— Tier 2 Preferred Brand Name Drugs	$200 per prescription
— Tier 3 Non-Preferred Brand Name Drugs	$200 per prescription
— Tier 4 Specialty Drug	$200 per prescription
Minimum Coinsurance	
— Tier 1 Generic Drugs	$10 per prescription
— Tier 2 Preferred Brand Name Drugs	$30 per prescription

— Tier 3 Non-Preferred Brand Name Drugs	$45 per prescription
— Tier 4 Specialty Drug	$60 per prescription
Home Delivery Prescription Drug Program	
Payment Level	
— Tier 1 Generic Drugs and generic diabetic supplies	$20 per prescription
— Tier 2 Preferred Brand Name Drugs and preferred brand name diabetic supplies	75% of the Eligible Charge per prescription
— Tier 3 Non-Preferred Brand Name Drugs and non-preferred brand name diabetic supplies for which there is no generic available	60% of the Eligible Charge per prescription
— If your Physician indicates dispense as written on the prescription, you will be responsible for the Copayment/Coinsurance Amount specified above and the following provision will not apply.	
— Tier 3 Non-Preferred Brand Name Drugs and non-preferred brand name diabetic supplies for which there is a generic available	60% of the Eligible Charge, minus the difference between the Generic and Brand Name Drugs costs per prescription
Lancets and Lancet Devices	100% of the Eligible Charge per prescription
Maximum Coinsurance	
— Tier 2 Preferred Brand Name Drugs	$250 per prescription
— Tier 3 Non-Preferred Brand Name Drugs	$250 per prescription
Minimum Coinsurance	

— Tier 2 Preferred Brand Name Drugs	$50 per prescription
— Tier 3 Non-Preferred Brand Name Drugs	$100 per prescription

Prescription Drug Out-of-Pocket Expense Limit

— Individual Out-of-Pocket Expense Limit for prescription drugs and diabetic supplies	$3,900 per benefit period
— Family Out-of-Pocket Expense Limit for prescription drugs and diabetic supplies	$7,800 per benefit period

VISION BENEFITS

Benefit Payment Level for routine vision examinations

— Participating Provider	80% of the U&C Fee*
— Non-Participating Provider	60% of the U&C Fee*

*Usual and Customary Fee

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.

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.

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.

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, Serious Mental Illness or Substance Use Disorder 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 Preauthorization, Emergency Mental Illness or Substance Use Disorder Admission Review and length of stay/service review for Inpatient Hospital admissions and/or review of Outpatient services for the treatment of Mental Illness and Substance Use 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 payor, 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 "charge master."

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.

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 and positron emission tomography (PET) scans.

DIALYSIS FACILITY.....means a facility (other than a Hospital) whose primary function is the treatment and/or provision of maintenance and/or training dialysis on an ambulatory basis for renal dialysis patients and which is duly licensed by the appropriate governmental authority to provide such services, 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. Only employees of the Employer who reside in California are eligible for to enroll for coverage for their Domestic Partners.

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

(i) you and your Domestic Partner have lived together for at least 6 months,

(ii) neither you nor your Domestic Partner is married to anyone else or has another Domestic Partner,

(iii) your Domestic Partner is at least 18 years of age, of the same sex, and mentally competent to consent to contract,

(iv) Your Domestic Partner is at least 62 years of age, of the same or opposite sex, and mentally competent to consent to contract,

(v) your Domestic Partner resides with you and intends to do so indefinitely,

(vi) you and your Domestic Partner have an exclusive mutual commitment similar to marriage, and

(vii) you and your Domestic Partner are not related by blood closer than would bar marriage in the state of your legal residence (i.e., the blood

relationship is not one which would forbid marriage in the state of your residence, if you and the Domestic Partner were of the opposite sex).

You and your Domestic Partner must be jointly responsible for each other's common welfare and must share financial obligations. Joint responsibility may be demonstrated by the existence of at least 3 of the following: a signed Affidavit of Domestic Partnership, a joint mortgage or lease, designation of you or your Domestic Partner as a beneficiary in the other partner's life insurance and retirement contract, designation of you or your Domestic Partner as the primary beneficiary in your or your Domestic Partner's will, durable property and health care powers of attorney, or joint ownership of a motor vehicle, checking account or credit account.

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.

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 100% of the base Medicare reimbursement rate, excluding any Medicare adjustment(s) which is/are based on information on the Claim; or

(ii) if there is no base Medicare reimbursement rate available for a particular Covered Service, or if the base Medicare reimbursement amount cannot otherwise be determined under subsection (i) above based upon the

information submitted on the Claim, the lesser of (a) the Provider's Billed Charges and (b) an amount determined by the Claim Administrator to be 100% 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 100% 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.....means the company with which you are employed.

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/INVESTIGATIONAL 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.

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 yourself but not your spouse and/or dependents.

INFERTILITY.....means the inability to conceive a child after one year of unprotected sexual intercourse or the inability to attain or maintain a viable pregnancy or sustain a successful pregnancy.

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.

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 a 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 100% of the base Medicare reimbursement rate and will exclude any Medicare adjustment(s) which is/are based on information on the Claim. Notwithstanding the preceding sentence, (1) the 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.....SEE EXCLUSIONS SECTION OF THIS BENEFIT BOOKLET.

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.

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

(i) Schizophrenia;

(ii) Paranoid and other psychotic disorders;

(iii) Bipolar disorders (hypomanic, manic, depressive and mixed);

(iv) Major depressive disorders (single episode or recurrent);

(v) Schizoaffective disorders (bipolar or depressive);

(vi) Pervasive developmental disorders;

(vii) Obsessive-compulsive disorders;

(viii) Depression in childhood and adolescence;

(ix) Panic disorder;

(x) Post-traumatic stress disorders (acute, chronic, or with delayed onset); and

(xi) Eating disorder, including, but not limited to, anorexia nervosa, bulimia nervosa, pica, rumination disorder, avoidant/restrictive food intake disorder, other specified feeding or eating disorder (OSFED), and any other eating disorder contained in the most recent version of the Diagnostic and Statistical Manual of Mental Disorder published by the American Psychiatric Association.

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.

PREAUTHORIZATION, PREAUTHORIZE 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.

A "Participating Prescription Drug Provider" means an independent retail Pharmacy, chain of retail Pharmacies, mail-order Pharmacy or specialty drug Pharmacy which has entered into an agreement to provide pharmaceutical services to participants in the benefit program. A retail Participating Pharmacy may or may not be a select Participating Pharmacy as that term is used in the Vaccinations Obtained Through Participating Pharmacies section.

A "Non-Participating Prescription Drug Provider" means a Pharmacy, including but not limited to, an independent retail Pharmacy, chain or retail

Pharmacies, home delivery Pharmacy or specialty drug Pharmacy which (i) has not entered into a written agreement with the Claim Administrator or (ii) has not entered into a written with any entity chosen by the Claim Administrator to administer its prescription drug program, for such Pharmacy to provide pharmaceutical services at the time Covered Services to participants in the benefit program at the time Covered Services are rendered.

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.

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 onsite 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 jaw bone 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.

For purposes of the routine vision examination benefit only, the following definition of Usual and Customary Fee will apply:

USUAL AND CUSTOMARY FEE.....means the fee as reasonably determined by the Claim Administrator, which is based on the fee which the Physician, Optician or Optometrist who renders the particular service usually charges his patients or customers for the same service and the fee which is within the range of fees other Physicians, Opticians or Optometrists of similar training and experience in the same geographic area charge their patients or customers for the same service, under similar or comparable circumstances.

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 illnesses or injuries as described in the VIRTUAL VISITS provision under the SPECIAL CONDITIONS AND PAYMENTS section of this benefit booklet.

ELIGIBILITY SECTION

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

- Meet the definition of an Eligible Person as determined by your Employer;
- Have applied for this coverage; and
- Have received an identification card.

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 laws). 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." If the GHP is a multi-employer or multiple employer plan, which has at least one participating employer that employs 20 or more employees, the MSP rules apply even with respect to employers of fewer than 20 employees (unless the plan elects the small employer exception under the statute).
3. In the case of disabled individuals under age 65, GHPs of employers that employ 100 or more employees, if the individual or a member of the individual's family has "current employee status." If the GHP is a multi-employer or multiple employer plan, which has at least one

participating employer that employs 100 or more employees, the MSP rules apply even with respect to employers of fewer than 100 employees.

PLEASE NOTE: SEE YOUR EMPLOYER OR GROUP ADMINISTRATOR 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 or your group administrator promptly to ensure that your Claims are processed in accordance with applicable MSP laws.

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

Child(ren) used hereafter, means a natural child(ren), a stepchild(ren), an adopted child(ren), a child(ren) for whom you have received a court order requiring that you are financially responsible for providing coverage under 26 years of age, a child(ren) who is in your custody under an interim court order of adoption or who is placed with you for adoption vesting temporary care.

Your spouse is not eligible for coverage under this benefit booklet if he or she has coverage through their own employer.

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.

Your enrolled Domestic Partner and his or her enrolled children who have not attained the limiting age stated above will be covered. 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, if the newborn child(ren) has been added as a dependent under the employee's coverage. Please notify your Group Administrator within 31 days of the date of birth so that your membership records can be adjusted.

Any children who are incapable of self-sustaining employment and are dependent upon you or other care providers for lifetime care and supervision because of a disabling condition occurring prior to reaching the limiting age will be covered regardless of age if they were covered prior to reaching the limiting age stated above.

Any children who are under your legal guardianship or who are in your custody under an interim court order of adoption or who are placed with you for adoption vesting temporary care will be covered.

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

This coverage does not include benefits for Maternity Services for dependent child(ren), unless complications of pregnancy occur for the mother.

CHANGING FROM INDIVIDUAL TO FAMILY COVERAGE OR ADDING DEPENDENTS TO FAMILY COVERAGE

You can change from Individual to Family Coverage or add dependents to your Family Coverage because of any of the following events:

- Marriage.
- Establishment of a Domestic Partnership.
- Birth, adoption or placement for adoption of a child.
- Obtaining legal guardianship of a child.
- Loss of eligibility for other health coverage for you or your dependent if:
    a. The other coverage was in effect when you were first eligible to enroll for this coverage;
    b. The other coverage is not terminating for cause (such as failure to pay premiums or making a fraudulent claim); and
    c. Where required, you stated in writing that coverage under another group health plan or other health insurance coverage was the reason for declining enrollment in this coverage.

  This includes, but is not limited to, loss of coverage due to:
    a. Legal separation, divorce, cessation of dependent status, death of an employee, termination of employment, or reduction in the number of hours of employment;
    b. In the case of HMO, coverage is no longer provided because an individual no longer resides in the service area or the HMO no longer offers coverage in the HMO service area in which the individual resides;

c. Reaching a lifetime limit on all benefits in another group health plan;

d. Another group health plan no longer offering any benefits to the class of similarly situated individuals that includes you or your dependent;

e. When Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility; or

f. When you or your dependents become eligible for a premium assistance subsidy under Medicaid or CHIP.

- Termination of employer contributions towards your or your dependent's other coverage.
- Exhaustion of COBRA continuation coverage or state continuation coverage.

When Coverage Begins

Your Family Coverage or the coverage for your additional dependents will be effective from the date of the event if you apply for this change within 31 days of any of the following events:

- Marriage.
- Establishment of a Domestic Partnership.
- Birth, adoption, or placement of adoption of a child.
- Obtaining legal guardianship of a child.

Your Family Coverage or the coverage for your additional dependents will be effective from the date you apply for coverage if you apply within 31 days of any of the following events:

- Loss of eligibility for other coverage for you or your dependent, except for loss of coverage due to reaching a lifetime limit on all benefits.
- Termination of employer contributions towards your or your dependent's other coverage.
- Exhaustion of COBRA continuation coverage or state continuation coverage.

If coverage is lost in another group health plan because a lifetime limit on all benefits is reached under that coverage and you apply for Family Coverage or to add dependents within 31 days after a claim is denied due to reaching the lifetime limit, your Family Coverage or the coverage for your additional dependents will be effective from the date your claim was denied.

Your Family Coverage or the coverage for your additional dependents will be effective from the date of the event if you apply for this change within 60 days of any of the following events:

- Loss of eligibility for you or your dependents when Medicaid or CHIP coverage is terminated as a result of loss of eligibility; or

- You or your dependents become eligible for a premium assistance subsidy under Medicaid or CHIP.

You must request this special enrollment within 60 days of the loss of Medicaid or CHIP coverage, or within 60 days of when eligibility for premium assistance under Medicaid or CHIP is determined. Coverage will be effective no later than the first of the month after the special enrollment request is received.

Late Applicants

If you do not apply for Family Coverage or to add dependents within the required number of days of the event, you can apply at any time to make those changes. Such changes will be effective on a date that has been mutually agreed to by your Employer and the Claim Administrator.

CHANGING FROM FAMILY TO INDIVIDUAL COVERAGE

Should you wish to change from Family to Individual Coverage, you may do this at any time. Your Group Administrator will provide you with the application and tell you the date that the change will be effective.

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.

UTILIZATION REVIEW PROGRAM

The Claim Administrator has established the Utilization Review Program to assist you in determining the course of treatment that will maximize your benefits under this Health Care Plan. The Utilization Review Program requires a review of the following 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

Preauthorization is a requirement that you must obtain authorization from the Claim Administrator before you receive a certain type of Covered Services 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 Preauthorization. If Preauthorization 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 the Health Care Plan.

  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 PREAUTHORIZATION REVIEW

Outpatient Service Preauthorization 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), 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
- Functional Neuromuscular Electrical Stimulation (FNMES)
- 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" in 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.

For specific details about the preauthorization requirements for any of the above referenced Outpatient services, please call the customer service number on the back of your identification card. The Claim Administrator reserves the right to no longer require Preauthorization during your benefit period for any or all of the listed services. Updates to the list of services requiring Preauthorization may be confirmed by calling the customer service number.

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 preadmission or emergency review, the Claim Administrator will send a letter to your Physician and/or the Hospital confirming that you or your representative called the Claim Administrator and that an approved length of service or length of stay was assigned.

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.

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 Claim Administrator's Health Care 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 Claim Administrator 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 Health Care 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 or your Physician 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 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 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.

MEDICARE ELIGIBLE MEMBERS

The preadmission review provisions of this Utilization 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 Preauthorization 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, as described in this section, may result in a reduction of benefits. The Behavioral Health Unit 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.

Preauthorization is a requirement that you must obtain authorization from the Claim Administrator before you receive a certain type of Covered Services 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 Preauthorization. If Preauthorization 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.

PREAUTHORIZATION REVIEW

- **Inpatient Hospital Preauthorization Review**

  Preauthorization 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 Preauthorize 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 Preauthorize services for you, when

required, but it is your responsibility to ensure Preauthorization 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 Preauthorization Review**

  Preauthorization 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 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 Preauthorize services for you, when required, but it is your responsibility to ensure Preauthorization 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 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 Preauthorize services for you, when required, but it is your responsibility to ensure Preauthorization 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 Preauthorization 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.

OUTPATIENT SERVICE PREAUTHORIZATION REVIEW

- **Outpatient Service Preauthorization Review**

  Outpatient Service Preauthorization 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 for Outpatient services for the treatment of Mental Illness or Substance Use Disorder, you must, except as otherwise provided, Preauthorize the following Outpatient service(s) by calling the Behavioral Health Unit:

  - Psychological testing
  - Neuropsychological testing
  - Electroconvulsive therapy
  - Intensive Outpatient Programs
  - Repetitive Transcranial Magnetic Stimulation

  Providers may Preauthorize services for you, when required, but it is your responsibility to ensure Preauthorization requirements are satisfied, as described in this section. This call must be made at least one day prior to the scheduling of the planned Outpatient services(s). The Behavioral Health

Unit will obtain information regarding the Outpatient 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 an Outpatient service, 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.

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 Preauthorize 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 Preauthorize 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 Preauthorization 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 PREAUTHORIZE OR NOTIFY

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.

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

Each benefit period you must satisfy a $1,200 deductible for Covered Services rendered by Participating Provider(s) and a separate $2,400 deductible for Covered Services rendered by Non-Participating Provider(s) or Non-Administrator Provider(s). In other words, after you have claims for Covered Services for more than the deductible amount in a benefit period, your benefits will begin. This deductible will be referred to as the program deductible.

FAMILY DEDUCTIBLE

If you have Family Coverage and your family has reached the program deductible amount of $2,400 for Covered Services rendered by Participating Provider(s) and a separate $4,800 program 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 the program deductible in that benefit period. That is, for the remainder of that benefit period only, no other family member(s) is required to meet the program deductible before receiving benefits. A family member may not apply more than the individual program deductible amount toward the family program deductible.

In any case, should two or more members of your family ever receive Covered Services as a result of injuries received in the same accident, only one program deductible will be applied against those Covered Services.

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.

The level of benefits paid for Hospital Covered Services is generally greater when received in an Administrator Hospital or other Administrator facility.

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.

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. Emergency Accident Care
8. Emergency Medical Care
9. Bone Mass Measurement and Osteoporosis—Benefits will be provided for bone mass measurement and the diagnosis and treatment of osteoporosis
10. 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 $150. If you are admitted to the Hospital as an Inpatient immediately following emergency treatment, the emergency room Copayment will be waived.

However, Covered Services received for Emergency Accident Care and Emergency Medical Care resulting from criminal sexual assault or abuse 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.

Notwithstanding anything in this benefit booklet to the contrary, the method used to determine the Eligible Charge for Emergency care services will be equal to the greatest of the following three possible amounts:

1. the amount negotiated with Participating Providers for emergency care benefits furnished; or
2. the amount for the emergency care service calculated using the same method the Participating Providers generally uses to determine payments for Non-Participating Provider services but substituting the Participating cost sharing provisions for the Non-Participating Provider cost-sharing provisions; or
3. the amount that would be paid under Medicare for the emergency care service.

Each of these three amounts is calculated excluding any Non-Participating Provider Copayment or Coinsurance imposed with respect to the covered person.

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.

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 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.

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

disability, or (c) you have a medical condition requiring hospitalization or general anesthesia for dental care.

Benefits will be provided for anesthesia administered in connection with dental care treatment rendered in a dental office, oral surgeon's office, Hospital or Ambulatory Surgical Facility if you are under age 19 and have been diagnosed with an autism spectrum disorder or a developmental disability.

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

Autism spectrum disorder means.....a pervasive developmental disorder described by the American Psychiatric Association or the World Health Organization diagnostic manuals as an autistic disorder, atypical autism, Asperger Syndrome, Rett Syndrome, childhood disintegrative disorder, or pervasive developmental disorder not otherwise specified; or a special education classification for autism or other disabilities related to autism.

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

- It is attributable to cerebral palsy, epilepsy or any other condition, other than a Mental Illness, found to be closely related to an intellectual disability because that condition results in impairment of general intellectual functioning or adaptive behavior similar to that of individuals with an intellectual disability and requires treatment or services similar to those required for those individuals; for purposes of this definition, autism is considered a related condition;
- It manifested before the age of 22;
- It is likely to continue indefinitely; and
- It results in substantial functional limitations in 3 or more of the following areas of major life activity: i) self-care, ii) language, iii) learning, iv) mobility, v) self-direction, and vi) the capacity for independent living.

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. Sterilization Procedures (even if they are voluntary).
4. Gender reassignment—benefits for Covered Services received for gender reassignment Surgery, including related services and supplies, will be provided the same as any other condition.

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.

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.

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. Benefits for Outpatient Physical Therapy will be limited to a soft maximum of 30 visits per benefit period. Additional visits may be provided if such visits are Medically Necessary.

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 25 visits per benefit period. Benefits for muscle manipulations will not be provided for children under age 2.

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.

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.

Bone Mass Measurement and Osteoporosis—Benefits 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.

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.

Amino Acid-Based Elemental Formulas—Benefits will be provided for amino acid-based elemental formulas for the diagnosis and treatment of eosinophilic disorders or short-bowel syndrome, when the prescribing Physician has issued a written order stating that the amino acid-based elemental formula is Medically Necessary. If you purchase the formula at a Pharmacy, benefits will be provided at the Benefit Payment for Other Covered Services described in the OTHER COVERED SERVICES section of this benefit booklet.

Orthotic Devices

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

Your benefits for foot orthotics will be limited to two foot orthotic devices or one pair of foot orthotic devices per benefit period.

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.

Routine Vision Examination—Benefits will be provided for one routine vision examination(s), including glaucoma testing, refraction and a visual acuity test.

Benefits are limited to one routine vision examination every 24 consecutive months if you are under age 40.

Benefits are limited to one routine vision examination every 12 consecutive months if you are age 40 and over.

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.

Tobacco Cessation Drugs

Growth Hormone Therapy

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.

Benefits for routine vision examinations from a Participating Provider will be provided at 80% of the Usual and Customary Fee, after you have met your program deductible.

When you receive tobacco cessation drugs from a Participating Provider, benefits will be provided at 100% of the Maximum Allowance and your program deductible will not apply.

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.

Benefits for routine vision examinations from a Non-Participating Provider will be provided at 60% of the Usual and Customary Fee, 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, Covered Services for Emergency Accident Care and Emergency Medical Care resulting from a criminal sexual assault or abuse 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.

Notwithstanding anything in this benefit booklet to the contrary, the method used to determine the Maximum Allowance for Emergency care services will be equal to the greatest of the following three possible amounts:

1. the amount negotiated with Participating Providers for emergency care benefits furnished; or
2. the amount for the emergency care service calculated using the same method the Participating Providers generally uses to determine payments for Non-Participating Provider services but substituting the Participating cost sharing provisions for the Non-Participating Provider cost-sharing provisions; or
3. the amount that would be paid under Medicare for the emergency care service.

Each of these three amounts is calculated excluding any Non-Participating Provider Copayment or Coinsurance imposed with respect to the covered person.

Participating Providers are:

- Physicians
- Podiatrists
- Psychologists
- Certified Clinical Nurse Specialists
- Certified Nurse-Midwives
- Certified Nurse Practitioners
- Certified Registered Nurse Anesthetists
- Chiropractors
- Clinical Laboratories
- Clinical Professional Counselors
- Clinical Social Workers
- Durable Medical Equipment Providers
- Home Infusion Therapy Providers
- Occupational Therapists
- Optometrists
- Orthotic Providers
- Physical Therapists
- Prosthetic Providers
- Registered Dieticians
- Registered Surgical Assistants
- Retail Health Clinics

- Speech Therapists

who 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 are:

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

Who 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.

OTHER COVERED SERVICES

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.
- 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.

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.

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 Chicago 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 Providers are:

- Physicians
- Podiatrists
- Psychologists
- Certified Clinical Nurse Specialists
- Certified Nurse-Midwives
- Certified Nurse Practitioners
- Certified Registered Nurse Anesthetists
- Chiropractors
- Clinical Laboratories
- Clinical Professional Counselors
- Clinical Social Workers
- Durable Medical Equipment Providers
- Home Infusion Therapy Providers
- Occupational Therapists
- Optometrists
- Physical Therapists
- Registered Dieticians
- Registered Surgical Assistants
- Retail Health Clinics
- Speech Therapists

who 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 are:

- Physicians
- Podiatrists
- Psychologists

- Dentists
- Certified Clinical Nurse Specialists
- Certified Nurse-Midwives
- Certified Nurse Practitioners
- Certified Registered Nurse Anesthetists
- Chiropractors
- Clinical Laboratories
- Clinical Professional Counselors
- Clinical Social Workers
- Durable Medical Equipment Providers
- Home Infusion Therapy Providers
- Occupational Therapists
- Optometrists
- Physical Therapists
- Registered Dieticians
- Registered Surgical Assistants
- Retail Health Clinics
- Speech Therapists
- Other Professional Providers

who 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.**

— 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.

Blue Distinction Centers of Treatment (BDCT)

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

- Bariatric Surgery
- Transplants

The goal of Blue Distinction is to help you find specialty care while enabling and encouraging health care Providers to improve the overall quality and cost of care nationwide. Although your plan may require you to receive treatment at a Blue Distinction Center to get the highest level of benefits, you may still be covered at a non-Blue Distinction Center, but your out-of-pocket costs will usually be higher. Please refer to your Benefit Highlights section to see the payment levels for procedures performed at Blue Distinction Centers and procedures performed at other facilities. Blue Distinction benefit levels apply to facility benefits only. Travel and lodging benefits are the same as those outlined in the Human Organ Transplants section.

Blue Distinction or Blue Distinction Plus Designated Center Providers

When you receive Covered Services for a human organ transplant or bariatric Surgery from a Blue Distinction or Blue Distinction Plus Designated Center facility or Provider, benefits will be provided at 80% of the Eligible Charge or 80% of the Maximum Allowance after you have met your program deductible.

Participating Provider

Benefits will not be provided for Covered Services for a human organ transplant or bariatric Surgery from a Participating Provider.

Non-Participating Provider

Benefits will not be provided for Covered Services for a human organ transplant or bariatric Surgery from a Non-Participating Provider.

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.

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; and
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.

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 4. 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 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 50
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. 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

12. Obesity screening and counseling
13. Sexually transmitted infections (STI) counseling
14. Tobacco use screening and cessation interventions for tobacco users
15. Syphilis screening for adults at higher risk
16. Exercise interventions to prevent falls in adults age 65 years and older who are at increased risk for falls
17. Hepatitis C virus (HCV) screening for adults at increased risk, and one time for everyone born between 1945-1965
18. Hepatitis B virus screening for persons at high risk for infection
19. Counseling children, adolescents and young adults who have fair skin about minimizing their exposure to ultraviolet radiation to reduce risk for skin cancer
20. Lung cancer screening in adults 55 and older who have a 30 pack-year smoking history and currently smoke or have quit within the past 15 years
21. Screening for high blood pressure in adults age 18 years or older
22. Screening for abnormal blood glucose and type II diabetes mellitus as part of cardiovascular risk assessment in adults who are overweight or obese
23. 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
24. Tuberculin testing for adults 18 years or older who are at risk of tuberculosis.

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 mellitus 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. Sexually transmitted infections (STI) counseling
21. Syphilis screening for all pregnant women or other women at increased risk
22. Well-woman visits to obtain recommended preventive services
23. Urinary incontinence screening
24. Breast cancer mammography screenings, including breast tomosynthesis and, if Medically Necessary, a screening MRI
25. Intrauterine device (IUD) services related to follow-up and management of side effects, counseling for continued adherence, and device removal
26. Aspirin use for pregnant women to prevent preeclampsia
27. Screening for preeclampsia in pregnant women with blood pressure measurements throughout pregnancy.

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
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.

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 EKG;
- Routine x-ray;
- Routine ovarian cancer screening;
- Routine colorectal cancer screening x-ray;
- Routine colonoscopy/flexible sigmoidoscopy/sigmoidoscopy - one examination every ten years if you are age 50 and older;
- Routine digital rectal examinations and Prostate test.

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.

If you are under age 50, benefits for a colonoscopy, flexible sigmoidoscopy or sigmoidoscopy, regardless of diagnosis, will be provided as described in the HOSPITAL BENEFIT SECTION and the PHYSICIAN BENEFIT SECTION of this benefit booklet.

If you are age 50 or older, benefits for Covered Services for one routine colorectal screening will include a colonoscopy, flexible sigmoidoscopy or sigmoidoscopy. If the routine examination reveals a medical condition, such as the removal of polyps, the examination will be provided at 100% of the Eligible Charge or 100% of the Maximum Allowance and your program deductible will not apply. If an additional colonoscopy, flexible sigmoidoscopy or sigmoidoscopy is performed within a ten year period, the examination will be provided as described in the HOSPITAL BENEFIT SECTION and the PHYSICIAN BENEFIT SECTION of this benefit booklet.

Non-Participating Provider

Benefits will not be provided when you receive Covered Services for wellness care from a Non-Participating Provider.

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 be provided for Covered Services received in an Uncertified Skilled Nursing Facility.

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.

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.

BARIATRIC SURGERY

Benefits for Covered Services received for bariatric Surgery will be provided under the HOSPITAL BENEFIT and PHYSICIAN BENEFIT sections 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 benefits 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 31 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 a therapeutic abortion if legal where performed.

INFERTILITY TREATMENT

Benefits will be provided the same as your benefits for any other condition for Covered Services rendered in connection with the diagnosis of Infertility.

Infertility means the inability to conceive a child after one year of unprotected sexual intercourse, the inability to conceive after one year of attempts to produce conception, the inability to conceive after an individual is diagnosed with a condition affecting fertility or the inability to attain or maintain a viable pregnancy, or sustain a successful pregnancy. The one year requirement will be waived if your Physician determines that a medical condition exists that makes conception impossible through unprotected sexual intercourse including, but not limited to, congenital absence of the uterus or ovaries, absence of the uterus or ovaries due to surgical removal due to a medical condition, or involuntary sterilization due to Chemotherapy or radiation treatments.

Unprotected sexual intercourse means sexual union between a male and female without the use of any process, device or method that prevents conception including, but not limited to, oral contraceptives, chemicals, physical or barrier contraceptives, natural abstinence or voluntary permanent surgical procedures and includes appropriate measures to ensure the health and safety of sexual partners.

However, your benefits for Covered Services for the diagnosis of infertility are limited to a lifetime maximum of $3,500.

TEMPOROMANDIBULAR JOINT DYSFUNCTION AND RELATED DISORDERS

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

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 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 or emergency room 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 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.

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, during one benefit period, your out-of-pocket expense (the amount remaining unpaid after benefits have been provided) equals $4,000, any additional eligible Claims for Participating Providers (except for those Covered Services specifically excluded below) during that benefit period will be paid in full up to the Eligible Charge or Maximum Allowance.

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

- the payments 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)
- charges for Covered Services which have a separate dollar maximum specifically mentioned in this benefit booklet

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 a Non-Administrator Provider
- Copayments resulting from noncompliance with the provisions of the UTILIZATION REVIEW PROGRAM and/or the CLAIM ADMINISTRATOR'S BEHAVIORAL HEALTH UNIT
- charges for Outpatient prescription drugs

If you have Family Coverage and your out-of-pocket expense as described above equals $8,000 during one benefit period, then, for the rest of the benefit period, all other family members will have benefits for Covered Services (except for those Covered Services specifically excluded above) provided at 100% of the Eligible Charge or Maximum Allowance. A member may not apply more than the individual out-of-pocket expense limit toward this amount.

For Non-Participating Providers

There is no Out-of-Pocket Expense Limit for Covered Services provided by a Non-Participating Provider.

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

Benefits for Covered Services rendered by a Participating or a Non-Participating Hospice Care Program Provider will be provided at 100% of the Eligible Charge after you have met your program deductible, provided such services are Medically Necessary.

When you receive Hospice Care Program Services from a Non-Administrator Provider, benefits will be provided at 60% of the Eligible Charge after you have met your program deductible.

OUTPATIENT PRESCRIPTION DRUG PROGRAM BENEFIT SECTION

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

Although you can go to the Pharmacy of your choice, your benefit for drugs and supplies will be greater when you purchase them from a Participating Pharmacy. You can visit the Claim Administrator's website at *www.bcbsil.com* for a list of Participating Pharmacies. The Pharmacies that are Participating Prescription Drug Pharmacies may change from time to time. You should check with your Pharmacy before purchasing drugs or supplies to make certain of its participation status.

The benefits of this section are subject to all of the terms and conditions of this 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.

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

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

AVERAGE WHOLESALE PRICE.....means any one of the recognized published averages of the prices charged by wholesalers in the United States for the drug products they sell to a Pharmacy.

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

COINSURANCE AMOUNT.....means the percentage amount paid by you for each Prescription filled or refilled through a Participating Pharmacy or Non-Participating Pharmacy.

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

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

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

(i) Which is Medically Necessary and is ordered by a Health Care Practitioner naming you as the recipient;

(ii) For which a written or verbal Prescription is provided by a Health Care Practitioner;

(iii) For which a separate charge is customarily made;

(iv) Which is not consumed or administered at the time and place that the Prescription is written;

(v) For which the FDA has given approval for at least one indication; and

(vi) Which is dispensed by a Pharmacy and is received by you while covered under this Benefit Section, **except when** received from a Provider's office, or during confinement while a patient in a Hospital or other acute care institution or facility (refer to the EXCLUSIONS provision later in this Benefit Section).

DRUG LIST.....means a list of drugs that may be covered under this Benefit Section. A current list is available on the Claim Administrator's website at https://www.bcbsil.com/member/prescription-drug-plan-information/drug-list . You may also contact a customer service representative at the telephone number shown on the back of your identification card for more information. Changes to this list will occur as frequently as quarterly.

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

to you at the time you receive Covered Services, either of the following charges for Covered Services:

(i) the charge which the particular Prescription Drug Provider usually charges for Covered Services, or

(ii) the agreed upon cost between a Participating Pharmacy and a Blue Cross and Blue Shield Plan or the entity chosen by the Claim Administrator to administer its prescription drug program, whichever is lower.

GENERIC DRUG.....means a drug that has the same active ingredient as a Brand Name Drug and is allowed to be produced after the Brand Name Drug's patent has expired. In determining the brand or generic classification for Covered Drugs and corresponding payment level, the Claim Administrator utilizes the generic/brand status assigned by a nationally recognized provider of drug product database information. You should know that not all drugs identified as "generic" by the drug product database, manufacturer, Pharmacy or your Physician will adjudicate as generic. Generic Drugs are listed on the Drug List which is available by accessing the Claim Administrator's website at *www.bcbsil.com*. You may also contact customer service for more information.

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

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

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

NATIONAL DRUG CODE (NDC).....means a national classification system for the identification of drugs.

NON-PARTICIPATING PHARMACY OR NON-PARTICIPATING PRESCRIPTION DRUG PROVIDER.....has the meaning set forth in the DEFINITIONS SECTION of this benefit booklet.

NON-PREFERRED BRAND NAME DRUG.....means a Brand Name Drug that is identified on the Drug List as a Non-Preferred Brand Name Drug. The Drug List is accessible by accessing the Claim Administrator's website at *www.bcbsil.com*.

PARTICIPATING PHARMACY OR PARTICIPATING PRESCRIPTION DRUG PROVIDER.....has the meaning set forth in the DEFINITIONS SECTION of this benefit booklet.

PHARMACY.....has the meaning set forth in the DEFINITIONS SECTION of this benefit booklet.

PREFERRED BRAND NAME DRUG.....means a Brand Name Drug, that is identified on the Drug List as a Preferred Brand Name Drug. The Drug List is accessible by accessing the Claim Administrator's website at *www.bcbsil.com*.

PRESCRIPTION.....means a written or verbal order from a Health Care Practitioner to a pharmacist for a drug to be dispensed. Prescriptions written by a Health Care Practitioner located outside the United States to be dispensed in the United States are not covered under this Benefit Section.

SPECIALTY DRUGS.....means prescription drugs generally prescribed for use in limited patient populations or diseases. These drugs are typically injected, but may also include drugs that are high cost oral medications and/or that have special storage requirements. In addition, patient support and/or education may be required for these drugs. The list of Specialty Drugs is subject to change. To determine which drugs are Specialty Drugs, refer to the Drug List by accessing the Claim Administrator's website at *www.bcbsil.com* or call the customer service toll-free number on your identification card.

SPECIALTY PHARMACY PROVIDER.....means a Participating Prescription Drug Provider that has a written agreement with the Claim Administrator or the entity chosen by the Claim Administrator to administer its prescription drug program to provide Specialty Drugs to you.

ABOUT YOUR BENEFITS

Drug List

The Drugs listed on the Drug List are selected by the Claim Administrator based upon the recommendations of a committee, which is made up of current and previously practicing physicians and pharmacists from across the country, some of whom are employed by or affiliated with the Claim Administrator. The committee considers existing drugs approved by the FDA, as well as those newly FDA approved for inclusion on the Drug List. Entire drugs classes are also regularly reviewed. Some of the factors committee members evaluate include each drug's safety, effectiveness, cost and how it compares with drugs currently on the Drug List.

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

The Drug List and any modifications will be made available to you. By accessing the Claim Administrator's website at *www.bcbsil.com* or calling the customer service toll-free number on your identification card, you will be able to determine the Drug List that applies to you and whether a particular drug is on the Drug List.

Prior Authorization/Step Therapy Requirement

Prior Authorization (PA): Your benefit program requires prior authorization for certain drugs. This means that your doctor will need to submit a prior authorization request for coverage of these medications and the request will need to be approved before the medication will be covered under the plan. You and your Physician will be notified of the prescription drug administrator's determination. If Medically Necessary criteria is not met, coverage will be denied and you will be responsible for the full charge incurred.

Step Therapy (ST): The step therapy program helps manage costs of expensive drugs by redirecting patients, when appropriate, to equally effective alternatives. The program requires that members starting a new drug treatment use a prerequisite drug first when appropriate. If the prerequisite drug is not effective, a targeted drug may then be acquired in the second step. You will be required to pay the applicable Copayment Amount or Coinsurance Amount for the targeted drug. Although you may currently be on therapy, your request for a targeted drug may need to be reviewed to see if the criteria for coverage of further treatment has been met. A documented treatment with a prerequisite drug may be required for continued coverage of the targeted drug.

To find out more about prior authorization/step therapy requirements or to determine which drugs or drug classes require prior authorization or step therapy, you should refer to the Drug List by accessing the Claim Administrator's website at *www.bcbsil.com* or call the customer service toll-free number on your identification card. Please refer to the Drug List provision of this section for more information about changes to these programs.

You, your prescribing health care Provider, or your authorized representative, can ask for an exception if your drug is not on (or is being removed from) the Drug List, if the drug requires prior authorization before it may be covered, or if the drug required as part of step therapy has been found to be (or likely to be) not right for you or does not work as well in treating your condition. To request this exception, you, your prescribing Provider, or your authorized representative, can call the number on the back of your identification card to ask for a review. The Claim Administrator will let you, your prescribing Provider, or authorized representative, know the coverage decision within 15 calendar days after they receive your request. If the coverage request is denied, the Claim Administrator will let you, your prescribing Provider, or authorized representative know why it was denied and offer you a covered alternative drug (if applicable). If your exception is denied, you may appeal the decision according to the appeals process you will receive with the denial determination.

If you have a health condition that may jeopardize your life, health or keep you from regaining function, or your current drug therapy uses a non-covered drug, you, your prescribing Provider, or your authorized representative, may be able to ask for an expedited review process. The Claim Administrator will let you, your prescribing Provider, or authorized representative know the coverage decision within 72 hours after they receive your request for an expedited review. If the coverage request is denied, the Claim Administrator will let you, your prescribing

Provider, or authorized representative know why it was denied and offer you a covered alternative drug (if applicable). If your exception is denied, you may appeal the decision according to the appeals and external exception review process you will receive with the denial determination. Call the number on the back of your identification card if you have any questions.

Dispensing Limits

Drug dispensing limits are designed to help encourage medication use as intended by the FDA. Coverage limits are placed on medications in certain drug categories. The Claim Administrator evaluates and updates dispensing limits quarterly.

If you require a prescription in excess of the dispensing limit established by the Claim Administrator, ask your Health Care Practitioner to submit a request for clinical review on your behalf. The request will be approved or denied after evaluation of the submitted clinical information. If Medically Necessary criteria is not met, you will be responsible for the full cost of the prescription beyond what your coverage allows.

Payment for benefits covered under this section may be denied if drugs are dispensed or delivered in a manner intended to change, or having the effect of changing or circumventing, the stated maximum quantity limitation.

To determine if a specific drug is subject to this limitation, you can refer to the Claim Administrator's website at *www.bcbsil.com* or call the customer service toll-free number on your identification card.

Day Supply

In order to be eligible for coverage under this benefit booklet, the prescribed day supply must be Medically Necessary and must not exceed the maximum day supply limitation described in this benefit booklet. Payment for benefits covered under this Benefit Section may be denied if drugs are dispensed or delivered in a manner intended to change, or having the effect of changing or circumventing, the stated maximum day supply limitation. Specialty Drugs are limited to a 30 day supply. For information on these drugs call the customer service toll-free number located on your identification card. However, early prescription refills of topical eye medication used to treat a chronic condition of the eye will be eligible for coverage after at least 75% of the predicted days of use and the early refills requested do not exceed the total number of refills prescribed by the prescribing Physician or Optometrist.

Oral Chemotherapy (Oncology) Split Fill Program

If this is your first time using select oral chemotherapy medications or you have not filled one of those oral chemotherapy medications recently, you may only be able to receive benefits for a partial fill (14-15 day supply) of the medication for up to the first three (3) months of therapy. This is to help see how the medication is working for you. Your Copayment Amount and/or Coinsurance Amount may be adjusted to align with the number of pills dispensed. If the medication is working for you and your Physician wants you to continue on this medication,

you may be eligible to receive up to a 30-day supply after completing up to three (3) months of the partial supply. Call the customer service toll-free number on your identification card if you have any questions.

Controlled Substances Limitations

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

Extended Prescription Drug Supply Program

Your coverage includes benefits for a 90 day supply of maintenance type drugs, Specialty Drugs and diabetic supplies purchased from a Participating Prescription Drug Provider (which may only include retail pharmacies). Benefit payment amounts are listed in this Benefit Section the Benefit Highlights section of this benefit booklet.

Benefits will not be provided for a supply drugs or diabetic supplies purchased from a Prescription Drug Provider not participating in the extended retail prescription drug supply program.

COVERED SERVICES

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

1. Has been approved by the FDA for the diagnosis and condition for which it was prescribed; or
2. Has been approved by the FDA for at least one indication; and
3. Is recognized by one of the following for the indication(s) of which the drug is prescribed to treat you for a chronic, disabling or life threatening illness:

   a. a prescription drug reference compendium, or

   b. substantially accepted peer-reviewed medical literature.

Some drugs are manufactured under multiple names and have many therapeutic equivalents. In such cases, the Claim Administrator may limit benefits to specific therapeutic equivalents. If you do not accept the therapeutic equivalents that are covered under this Benefit Section, the drug purchased will not be covered under any benefit level.

A separate Copayment Amount/Coinsurance Amount will apply to each fill of a medication having a unique strength, dosage, or dosage form.

Injectable Drugs

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

Immunosuppressant Drugs

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

Opioid Antagonists

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

Diabetic Supplies for Treatment of Diabetes

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

- Test strips specified for use with a corresponding blood glucose monitor
- Lancets and lancet devices
- Visual reading strips and urine testing strips and tablets which test for glucose, ketones, and protein
- Insulin and insulin analog preparations
- Injection aids, including devices used to assist with insulin injection and needleless systems
- Insulin syringes
- Biohazard disposable containers
- Prescriptive and non-prescriptive oral agents for controlling blood sugar levels
- Glucagon emergency kits

A separate Copayment Amount/Coinsurance Amount will be required for both insulin and insulin syringes regardless if they are obtained on the same day.

Self-Administered Cancer Medications

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

Specialty Drugs

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

SELECTING A PHARMACY

Participating Pharmacy

When you choose to go to a Participating Pharmacy:

- present your identification card to the pharmacist along with your Prescription,
- provide the pharmacist with the birth date and relationship of the patient,
- pay the applicable deductible, if any, and
- pay the appropriate Coinsurance Amount/Copayment Amount for each Prescription filled or refilled and the pricing difference when it applies to the Covered Drug you receive.
- the difference in cost between the brand name drug and its generic equivalent will not be applied toward the medical out-of-pocket expense limit and/or the prescription drug out-of-pocket expense limit.

Participating Pharmacies have agreed to accept as payment in full the least of:

- the billed charges, or
- the Eligible Charge, or
- the amount for which you are responsible for as described under the BENEFIT PAYMENT FOR PRESCRIPTION DRUGS provision later in this Benefit Section.

You may be required to pay for limited or non-Covered Services. No Claim forms are required if you follow the above procedures.

If you are unsure whether a Pharmacy is a Participating Pharmacy, you may access the Claim Administrator's website at *www.bcbsil.com* or call the customer service toll-free number on your identification card.

Non-Participating Pharmacy

If you choose to have a Prescription filled at a Non-Participating Pharmacy, you must pay the Pharmacy the full amount of its bill and submit a Claim form to the Claim Administrator or to the prescription drug administrator with itemized receipts verifying that the Prescription was filled. The Claim Administrator will reimburse you for Covered Drugs equal to:

- the Copayment Amount/Coinsurance Amount indicated,
- less the amount for which you are responsible for as described under the BENEFIT PAYMENT FOR PRESCRIPTION DRUGS provision later in this Benefit Section.

Please refer to the provision entitled "Filing Outpatient Prescription Drug Claims" in the HOW TO FILE A CLAIM AND APPEALS PROCEDURES section of this benefit booklet.

Home Delivery Prescription Drug Program

The Home Delivery Prescription Drug Program provides delivery of Covered Drugs directly to your home address. In addition to the benefits described in this Benefit Section, your coverage includes benefits for Maintenance Drugs and diabetic supplies obtained through the Home Delivery Prescription Drug Program.

Some drugs may not be available through the Home Delivery Prescription Drug Program. For a listing of Maintenance Drugs or if you have any questions about the Home Delivery Prescription Drug Program, need assistance in determining the amount of your payment, or need to obtain the home delivery order form, you may access the Claim Administrator's website at *www.bcbsil.com* or call the customer service toll-free number on your identification card. Mail the completed form, your prescription and payment to the address indicated on the form.

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

When you obtain Maintenance Drugs through the Home Delivery Prescription Drug Program, benefits will be provided according to the **Home Delivery Prescription Drug Program** payment provision described later in this Benefit Section.

For information about the Home Delivery Prescription Drug Program, contact your employer or group administrator.

90-Day Supply Program

The mail order program provides delivery of Covered Drugs directly to your home address. If you and your covered dependents elect to use the mail order service, refer to **Home Delivery Prescription Drug Program** provision below for applicable payment levels.

In order to receive benefits for Maintenance Drugs, you must obtain these medications through the mail order program or through one of the preferred extended supply pharmacies. For a listing of Maintenance Drugs, you may access the website at *www.bcbsil.com* or contact customer service at the toll-free number on your identification card. Benefits are available for the original prescription plus one refill at a retail Pharmacy for Maintenance Drugs. For the third fill of the medication, benefits are only available for Maintenance Drugs through the mail order program or through one of the preferred extended supply pharmacies. Benefits are not available if you continue to fill your prescription for Maintenance Drugs at a non-extended supply retail Pharmacy.

Some drugs may not be available through the mail order program. If you have questions about this mail order program, need assistance in determining the

amount of your payment or need to obtain the mail order prescription form, you may access the website at *www.bcbsil.com* or contact customer service at the toll-free number on your identification card. Mail the completed form, your prescription(s) and payment to the address indicated on the form.

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

Specialty Pharmacy Program

This program provides delivery of medications directly to your Health Care Practitioner, administration location or to your home if you are undergoing treatment for a complex medical condition. To determine which drugs are Specialty Drugs or to locate a Specialty Pharmacy Provider, you should refer to the Drug List by accessing the Claim Administrator's website at *www.bcbsil.com* or call the customer service toll-free number on your identification card.

The Specialty Pharmacy Program delivery service offers:

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

In order to receive maximum benefits for Specialty Drugs, you must obtain the Specialty Drugs from the preferred Specialty Pharmacy Provider. When you obtain Specialty Drugs from the preferred Specialty Pharmacy Provider, benefits will be provided according to the payment provisions indicated in this Benefit Section for a Participating Pharmacy.

YOUR COST

Out-of-Pocket Expense Limit

If, during one benefit period, your out-of-pocket expense (the amount remaining unpaid after benefits have been provided) for Outpatient prescription drugs and diabetic supplies equals $3,900, any additional eligible Claims for outpatient prescription drugs during that benefit period will be paid at 100% of the Eligible Charge.

If you have Family Coverage and your out-of-pocket expense for outpatient prescription drugs and diabetic supplies equals $7,800 during one benefit period, then, for the rest of the benefit period, all other family members will have benefits provided at 100% of the Eligible Charge.

BENEFIT PAYMENT FOR PRESCRIPTION DRUGS

How Member Payment is Determined

The amount that you are responsible for is based upon the drug tiers as described below and shown in the Benefit Highlights section.

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

If you or your Provider request a Brand Name Drug when a generic equivalent is available, you will be responsible for the Non-Preferred Brand Name Drug payment amount, plus the difference in cost between the Brand Name Drug and the generic equivalent, except as otherwise provided in this benefit booklet.

To receive additional information about your benefits for a drug, visit the Claim Administrator's website at *www.bcbsil.com* and log in to Blue Access for Members℠ (BAM) or call the number on the back of your identification card. Benefits will be provided as shown in the Benefit Highlights section and as described below.

Retail Pharmacy

The benefits you receive and the amount you pay will differ depending upon the type of drugs purchased and whether they are obtained from a Participating Prescription Drug Provider.

When you obtain Tier 1 Generic Drugs from a Participating Prescription Drug Provider, you must pay a Copayment Amount of:

- **$10 for each prescription** - for Tier 1 Generic Drugs.

When you obtain Covered Drugs from a Participating Prescription Drug Provider, benefits will be provided at:

- **75% of the Eligible Charge for each prescription** - for Tier 2 Preferred Brand Name Drugs.
- **60% of the Eligible Charge for each prescription** - for Tier 3 Non-Preferred Brand Name Drugs for which there is no Generic Drug available.
- If your Physician indicates dispense as written on the prescription, benefits will be provided at the Coinsurance Amount specified above and the following provision will not apply.
- **60% of the Eligible Charge, minus the cost difference between the Generic and Brand Name Drugs, as determined by the Claim**

Administrator, for each prescription - for Tier 3 Non-Preferred Brand Name Drugs for which there is a Generic Drug available.

- **60% of the Eligible Charge for each prescription** - for Tier 4 Specialty Drugs.
- The difference in cost between the brand name drug and its generic equivalent will not be applied toward the medical out-of-pocket expense limit and/or the prescription drug out-of-pocket expense limit.

You may not be required to pay the difference in cost between the allowable amount of the Brand Name Drug and the allowable amount of the Generic Drug if there is a medical reason (e.g. adverse event) you need to take the Brand Name Drug and certain criteria are met. Your Provider can submit a request to waive the difference in cost between the allowable amount of the Brand Name Drug and the allowable amount of the Generic Drug. In order for this request to be reviewed, your Provider must send in a MedWatch form to the Food and Drug Administration (FDA) to let them know the issues you experienced with the generic equivalent. Your Physician must provide a copy of this form when requesting the waiver. The FDA MedWatch form is used to document adverse events, therapeutic inequivalence/failure, product quality problems, and product use/medication error. This form is available on the FDA website. If the waiver is granted, applicable Copayment Amounts and/or Coinsurance Amounts will still apply. For additional information, contact the customer service number on the back of your identification card or visit *www.bcbsil.com*.

When you obtain diabetic supplies from a Participating Prescription Drug Provider, benefits will be provided as described above for each prescription. You will be responsible for the remaining Eligible Charge.

Benefits for lancets and lancet devices will be provided differently than diabetic supplies. There will be no cost to you for lancets and lancet devices.

When you obtain Covered Drugs, including diabetic supplies from a Participating Pharmacy, the **minimum** amount of your Coinsurance Amount will be:

- **$25 for each prescription** - for Tier 2 Preferred Brand Name Drugs.
- **$50 for each prescription** - for Tier 3 Non-Preferred Brand Name Drugs.
- **$50 for each prescription** - for Tier 4 Specialty Drug.

When you obtain Covered Drugs from a Participating Pharmacy, the **maximum** amount of your Coinsurance Amount will be:

- **$150 for each prescription** - for Tier 2 Preferred Brand Name Drugs.
- **$150 for each prescription** - for Tier 3 Non-Preferred Brand Name Drugs.
- **$150 for each prescription** - for Tier 4 Specialty Drug.

When you obtain Covered Drugs from a Non-Participating Prescription Drug Provider, benefits will be provided at:

- **60% of the Eligible Charge for each prescription** - for Tier 1 Generic Drugs.

- **60% of the Eligible Charge for each prescription** - for Tier 2 Preferred Brand Name Drugs.
- **60% of the Eligible Charge for each prescription** - for Tier 3 Non-Preferred Brand Name Drugs for which there is no Generic Drug available.
- If your Physician indicates dispense as written on the prescription, benefits will be provided at the Coinsurance Amount specified above and the following provision will not apply.
- **60% of the Eligible Charge, minus the cost difference between the Generic and Brand Name Drugs, as determined by the Claim Administrator, for each prescription** - for Tier 3 Non-Preferred Brand Name Drugs for which there is a Generic Drug available.
- **60% of the Eligible Charge for each prescription** - for Tier 4 Specialty Drugs.
- The difference in cost between the brand name drug and its generic equivalent will not be applied toward the medical out-of-pocket expense limit and/or the prescription drug out-of-pocket expense limit.

When you obtain Covered Drugs from a Non-Participating Pharmacy, the **minimum** amount of your Coinsurance Amount will be:

- **$10 for each prescription** - for Tier 1 Generic Drugs.
- **$30 for each prescription** - for Tier 2 Preferred Brand Name Drugs.
- **$45 for each prescription** - for Tier 3 Non-Preferred Brand Name Drugs.
- **$60 for each prescription** - for Tier 4 Specialty Drug.

When you obtain Covered Drugs from a Non-Participating Pharmacy, the **maximum** amount of your Coinsurance Amount will be:

- **$200 for each prescription** - for Tier 1 Generic Drugs.
- **$200 for each prescription** - for Tier 2 Preferred Brand Name Drugs.
- **$200 for each prescription** - for Tier 3 Non-Preferred Brand Name Drugs.
- **$200 for each prescription** - for Tier 4 Specialty Drug.

You may not be required to pay the difference in cost between the allowable amount of the Brand Name Drug and the allowable amount of the Generic Drug if there is a medical reason (e.g. adverse event) you need to take the Brand Name Drug and certain criteria are met. Your Provider can submit a request to waive the difference in cost between the allowable amount of the Brand Name Drug and the allowable amount of the Generic Drug. In order for this request to be reviewed, your Provider must send in a MedWatch form to the Food and Drug Administration (FDA) to let them know the issues you experienced with the generic equivalent. Your Physician must provide a copy of this form when requesting the waiver. The FDA MedWatch form is used to document adverse events, therapeutic inequivalence/failure, product quality problems, and product

use/medication error. This form is available on the FDA website. If the waiver is granted, applicable Copayment Amounts and/or Coinsurance Amounts will still apply. For additional information, contact the customer service number on the back of your identification card or visit *www.bcbsil.com*.

When you obtain diabetic supplies from a Non-Participating Prescription Drug Provider, benefits will be provided as described above for each prescription. You will be responsible for the remaining Eligible Charge.

Benefits for lancets and lancet devices will be provided differently than diabetic supplies. There will be no cost to you for lancets and lancet devices.

One prescription means up to a 30 consecutive day supply of a drug. Certain drugs may be limited to less than a 30 consecutive day supply. However, for certain Maintenance Drugs, larger quantities may be obtained through the Home Delivery Prescription Drug Program. For information on these drugs, contact your Participating Pharmacy or call the customer service toll-free number on your identification card. Benefits for prescription inhalants will not be restricted on the number of days before an inhaler refill may be obtained.

Mandatory Home Delivery Prescription Drug Program

Mandatory Home Delivery Prescription Drug Program requires you to obtain maintenance type drugs through the Home Delivery Prescription Drug Program in order to obtain maximum benefits. Medications and drugs included in this program are subject to change and other medications and drugs for other conditions may be added to this program.

You will have coverage at a retail pharmacy for the first two refills of a maintenance type drug. After the second refill, you must obtain maintenance type drugs through the Home Delivery Prescription Drug Program in order to receive maximum benefits.

You should refer to the Claim Administrator's website (www.bcbsil.com) or contact your Pharmacy to determine which drugs are classified as maintenance type drugs.

Home Delivery Prescription Drug Program

When you obtain Generic Drugs and diabetic supplies through the Home Delivery Prescription Drug Program, you must pay a Copayment Amount of:

- **$20 for each prescription** - for Tier 1 Generic Drugs.

When you obtain Covered Drugs and diabetic supplies through the Home Delivery Prescription Drug Program, benefits will be provided at:

- **75% of the Eligible Charge for each prescription** - for Tier 2 Preferred Brand Name Drugs.
- **60% of the Eligible Charge for each prescription** - for Tier 2 Non-Preferred Brand Name Drugs for which there is no generic drug available.

- If your Physician indicates dispense as written on the prescription, benefits will be provided at the Coinsurance Amount specified above and the following provision will not apply
- **60% of the Eligible Charge, minus the cost difference between the Generic and Brand Name Drugs, as determined by the Claim Administrator, for each prescription** - for Tier 3 Non-Preferred Brand Name Drugs for which there is a Generic Drug available.
- The difference in cost between the brand name drug and its generic equivalent will not be applied toward the medical out-of-pocket expense limit and/or the prescription drug out-of-pocket expense limit.

You may not be required to pay the difference in cost between the allowable amount of the Brand Name Drug and the allowable amount of the Generic Drug if there is a medical reason (e.g. adverse event) you need to take the Brand Name Drug and certain criteria are met. Your Provider can submit a request to waive the difference in cost between the allowable amount of the Brand Name Drug and the allowable amount of the Generic Drug. In order for this request to be reviewed, your Provider must send in a MedWatch form to the Food and Drug Administration (FDA) to let them know the issues you experienced with the generic equivalent. Your Physician must provide a copy of this form when requesting the waiver. The FDA MedWatch form is used to document adverse events, therapeutic inequivalence/failure, product quality problems, and product use/medication error. This form is available on the FDA website. If the waiver is granted, applicable Copayment Amounts and/or Coinsurance Amounts will still apply. For additional information, contact the customer service number on the back of your identification card or visit *www.bcbsil.com*.

When you obtain Covered Drugs, including diabetic supplies from a Participating Pharmacy, the **minimum** amount of your Coinsurance Amount will be:

- **$50 for each prescription** - for Tier 2 Preferred Brand Name Drugs.
- **$100 for each prescription** - for Tier 3 Non-Preferred Brand Name Drugs.

When you obtain Covered Drugs from a Participating Pharmacy, the **maximum** amount of your Coinsurance Amount will be:

- **$250 for each prescription** - for Tier 2 Preferred Brand Name Drugs.
- **$250 for each prescription** - for Tier 3 Non-Preferred Brand Name Drugs.

When you obtain diabetic supplies from a Participating Prescription Drug Provider, benefits will be provided as described above for each prescription. You will be responsible for the remaining Eligible Charge.

Benefits for lancets and lancet devices will be provided differently than diabetic supplies. There will be no cost to you for lancets and lancet devices.

One prescription means up to a 90 consecutive day supply of a drug. Certain drugs may be limited to less than a 90 consecutive day supply. For information on these drugs, contact your Participating Pharmacy or call the customer service toll-free

number on your identification card. Benefits for prescription inhalants will not be restricted on the number of days before an inhaler refill may be obtained.

Specialty Pharmacy Program

In order to receive maximum benefits for Specialty Drugs, you must purchase the Specialty Drugs from a Specialty Pharmacy Provider. When you purchase Specialty Drugs from a Specialty Pharmacy Provider, benefits will be provided according to the payment provisions described above for Participating Prescription Drug Providers.

If you obtain Specialty Drugs from a Provider that is not a Specialty Pharmacy Provider no benefits will be provided.

EXCLUSIONS

For purposes of this Benefit Section only, the following exclusions shall apply:

1. Drugs which are not included on the Drug List, unless specifically covered elsewhere in this benefit booklet and/or such coverage is required in accordance with applicable law or regulatory guideline.
2. Non-FDA approved drugs.
3. Drugs that are not shown on the Drug List, other than those specifically mentioned in this benefit booklet.
4. Drugs which do not by law require a Prescription from a Provider or Health Care Practitioner (except insulin, insulin analogs, insulin pens, and prescriptive and non-prescriptive oral agents for controlling blood sugar levels); and drugs or covered devices for which no valid Prescription is obtained.
5. Devices or durable medical equipment of any type (even though such devices may require a Prescription) such as, but not limited to, contraceptive devices, therapeutic devices, artificial appliances, or similar devices (except disposable hypodermic needles and syringes for self-administered injections and those devices listed as diabetes supplies).
6. Pharmaceutical aids such as excipients found in the USP-NF (United States Pharmacopeia-National Formulary), including, but not limited to preservatives, solvents, ointment bases and flavoring coloring diluting emulsifying and suspending agents.
7. Administration or injection of any drugs.
8. Vitamins (except those vitamins which by law require a Prescription and for which there is no non-prescription alternative).
9. Drugs dispensed in a Physician's or Health Care Practitioner's office or during confinement while as a patient in a Hospital, or other acute care institution or facility, including take-home drugs or samples; and drugs dispensed by a nursing home or custodial or chronic care institution or facility.

10. Covered Drugs, devices, or other Pharmacy services or supplies provided or available in connection with an occupational sickness or an injury sustained in the scope of and in the course of employment whether or not benefits are, or could upon proper claim be, provided under the Workers' Compensation law.
11. Any special services provided by the Pharmacy, including but not limited to, counseling and delivery.
12. Covered Drugs for which the Pharmacy's usual retail price to the general public is less than or equal to your cost determined under this Benefit Section.
13. Drugs which are repackaged by a company other than the original manufacturer.
14. Drugs required by law to be labeled: "Caution — Limited by Federal Law to Investigational Use," or experimental drugs, even though a charge is made for the drugs.
15. Drugs dispensed in quantities in excess of the day supply amounts stipulated in this Benefit Section, certain Covered Drugs exceeding the clinically appropriate predetermined quantity, or refills of any prescriptions in excess of the number of refills specified by the Physician or Health Care Practitioner or by law, or any drugs or medicines dispensed in excess of the amount or beyond the time period allowed by law.
16. Legend Drugs which are not approved by the FDA for a particular use or purpose or when used for a purpose other than the purpose for which the FDA approval is given, except as required by law or regulation.
17. Fluids, solutions, nutrients, or medications (including all additives and Chemotherapy) used or intended to be used by intravenous or gastrointestinal (enteral) infusion or by intravenous, intramuscular (in the muscle), intrathecal (in the spine), or intraarticular (in the joint) injection in the home setting, except as specifically mentioned in this benefit booklet. NOTE: This exception does not apply to dietary formula necessary for the treatment of phenylketonuria (PKU) or other heritable diseases.
18. Drugs, that the use or intended use of which would be illegal, unethical, imprudent, abusive, not Medically Necessary, or otherwise improper.
19. Drugs obtained by unauthorized, fraudulent, abusive, or improper use of the identification card.
20. Drugs used or intended to be used in the treatment of a condition, sickness, disease, injury, or bodily malfunction which is not covered under your employer's group health care plan, or for which benefits have been exhausted.
21. Rogaine, minoxidil, or any other drugs, medications, solutions, or preparations used or intended for use in the treatment of hair loss, hair thinning, or any related condition, whether to facilitate or promote hair growth, to replace lost hair, or otherwise.

22. Compounded drugs that do not meet the definition of Compound Drugs in this portion of your Benefit Section or that are determined to be high-risk compounds.
23. Cosmetic drugs used primarily to enhance appearance, including, but not limited to, correction of skin wrinkles and skin aging.
24. Retin A or pharmacologically similar topical drugs for persons over the age of 39.
25. Athletic performance enhancement drugs.
26. Allergy serum and allergy testing materials.
27. Some therapeutic equivalent drugs are manufactured under multiple names. In some cases, benefits may be limited to only one of the therapeutic equivalents available. If you do not choose the therapeutic equivalents that are covered under this Benefit Section, the drug purchased will not be covered under any benefit level.
28. Drugs in a drug class where there is an over-the-counter alternative available, unless otherwise determined by the Group Health Plan.
29. All Brand Name Drugs in a drug class where there is an over the counter alternative available.
30. Infertility drugs.
31. Medications in depot or long acting formulations that are intended for use longer than the covered days supply amount.
32. Devices and pharmaceutical aids.
33. Repackaged medications and institutional packs and drugs which are repackaged by anyone other than the original manufacturer.
34. Surgical supplies.
35. Ostomy products.
36. Diagnostic agents (except diabetic testing supplies or test strips).
37. General anesthetics.
38. Bulk powders.
39. New-to-market FDA-approved drugs which are subject to review by Prime Therapeutics Pharmacy and Therapeutic (P&T) Committee prior to coverage of the drug.
40. Drugs determined to have inferior efficacy or significant safety issues.
41. Benefits will not be provided for any self-administered drugs under this Benefit Section dispensed by a Physician.
42. Male condoms.
43. Drugs that are not considered Medically Necessary or treatment recommendations that are not supported by evidence-based guidelines or clinical practice guidelines.

44. Drugs prescribed and dispensed for the treatment of obesity or for use in any program of weight reduction, weight loss, or dietary control.
45. Compound Drugs.
46. Drugs without superior clinical efficacy which have lower cost therapeutics.

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 the Summary Plan Description document.

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

— Services or supplies that are furnished to you by the local, state or federal government and for any services or supplies to the extent payment or benefits are provided or available from the local, state or federal government (for example, Medicare) whether or not that payment or benefits are received, except in the case of Medicare, except however, this exclusion shall not be applicable to medical assistance benefits under Article V 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 the Summary Plan Description document for 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 the Summary Plan Description document if not provided in connection with a qualified cancer trial program.
- 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 the Summary Plan Description document.
- 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 the Summary Plan Description document.

— 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 the Summary Plan Description document.

— 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.

— Immunizations, unless otherwise specified in the Summary Plan Description document.

— Maintenance Occupational Therapy, Maintenance Physical Therapy and Maintenance Speech Therapy, except as specifically mentioned in the Summary Plan Description document.

— 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.

— Hearing aids or examinations for the prescription or fitting of hearing aids, unless otherwise specified in the Summary Plan Description document.

— Hypnotism or hypnotherapy.

— Diagnostic Service as part of routine physical examinations or check-ups, premarital examinations, determination of the refractive errors of the eyes, auditory problems, surveys, casefinding, research studies, screening, or similar procedures and studies, or tests which are Investigational, unless otherwise specified in the Summary Plan Description document.

— 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.

— Wigs (also referred to as cranial prostheses), unless otherwise specified in the Summary Plan Description document.

— Services and supplies rendered or provided for human organ or tissue transplants other than those specifically named in the Summary Plan Description document.

— 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 the Summary Plan Description document.

— Elective abortions; however benefits will be provided for therapeutic abortion.

- Services and supplies rendered or provided for the treatment of infertility including, but not limited to, Hospital services, Medical Care, therapeutic injections, fertility and other drugs, Surgery, artificial insemination and all forms of in-vitro fertilization.
- Services or supplies rendered or provided for Maternity Services for a dependent child(ren), unless complications of pregnancy occur for the mother.
- Reversals of sterilization.
- Acupuncture.
- Naprapathic services.
- Appliances and adjustments for Temporomandibular Joint Dysfunction.
- Marriage and family therapy counseling.
- Orthomolecular medicine, cytotoxin testing in conjunction with allergies or hair analysis.
- Work hardening programs, including all work related treatment and job hardening, unrelated to job performance.
- Services or supplies rendered or provided for the organ transplant expenses of a donor if the recipient is not covered by this plan. However, if the donor's expenses are not covered by the donor's own health insurance plan, benefits will be provided under this plan.
- Services or supplies rendered or provided for the treatment of obesity or for use in any program of weight reduction, weight loss, or dietary control, except as provided for bariatric Surgery as described in this benefit booklet.
- Motor vehicles, vehicle lifts for wheelchairs and scooters and stair lifts. However, benefits will be provided for electric wheelchairs if they are determined to be Medically Necessary and a manual wheelchair cannot be utilized.
- Vocational rehabilitation.
- 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.

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 under this Health Care Plan. In other words, the total payment from all of your coverages together will never be less than what would have been paid under this Health Care Plan if no other group coverages were involved. It is your obligation to notify the Claim Administrator of the existence of such other group coverages. COB does not apply to the Outpatient Prescription Drug Program Benefit Section.

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.

In order to prevent duplicate payment of benefits for a Claim, the Claim Administrator uses the following process to determine benefits when it is the secondary payer.

— determines what the payment for service would be following the payment provision of this coverage; and

— deducts from this resulting amount the amount paid by the primary payer. The difference is the amount that will be paid under this coverage.

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

This CONTINUATION COVERAGE RIGHTS UNDER COBRA section does not apply to Domestic Partners and their children.

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

Introduction

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

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage.

For additional information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

What Is COBRA Continuation Coverage?

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

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

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

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

- Your spouse dies;

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

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

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

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

When Is COBRA Coverage Available?

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

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event

occurs. Contact your employer and/or COBRA Administrator for procedures for this notice, including a description of any required information or documentation.

How Is COBRA Coverage Provided?

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

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

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

Disability Extension Of 18-Month Period Of Continuation Coverage

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

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

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a

maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

If You Have Questions

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

Keep Your Plan Informed Of Address Changes

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

Plan Contact Information

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

CONTINUATION COVERAGE RIGHTS UNDER COBRA

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

Introduction

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

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage.

For additional information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

What Is COBRA Continuation Coverage?

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

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

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

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

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

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

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

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

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

When Is COBRA Coverage Available?

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

You Must Give Notice of Some Qualifying Events

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

How Is COBRA Coverage Provided?

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

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

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

Disability Extension Of 18-Month Period Of Continuation Coverage

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

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

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

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

If You Have Questions

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

Keep Your Plan Informed Of Address Changes

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

Plan Contact Information

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

CONTINUATION OF COVERAGE 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.

NOTE: Certain employers may not be required to offer COBRA continuation coverage. See your Group Administrator if you have any questions about COBRA.

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.

FILING OUTPATIENT PRESCRIPTION DRUG CLAIMS

In certain situations, you will have to file your own Claims in order to obtain benefits for Outpatient prescription drugs. This is primarily true when you did not receive an identification card, the Pharmacy will not to transmit a Claim or you

received benefits from a Non-Participating Prescription Drug Provider. To do so, follow these instructions:

1. Complete a prescription drug Claim Form. These forms are available from your Employee Benefits Department or from the Claim Administrator's office.
2. Attach copies of all Pharmacy receipts to be considered for benefits. These receipts must be itemized.
3. Mail the completed Claim Form with attachments to:

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

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

Should you have any questions about filing Claims, please call the Claim Administrator.

INTERNAL CLAIMS DETERMINATIONS AND APPEALS PROCESS

INITIAL CLAIMS DETERMINATIONS

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

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

For Complaints and general Inquiries:

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

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:	**72 hours**
after receiving the completed Claim (if the initial Claim is incomplete), within:	**48 hours**

*You do not need to submit appeals of Urgent Care Clinical Claims in writing. You should call 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 preauthorization, 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.
- The Illinois Department of Insurance (IDOI) offers consumer assistance. If your standard or expedited (urgent) external review request does not qualify for review by your plan or its representatives, you may file an

appeal with the IDOI at the Springfield address below. Also, if you have questions about your rights, with to file a complaint or wish to take up your matter with the IDOI, you may use either address below:

IDOI Consumer Division
320 W. Washington St.
Springfield, Illinois 62767
1-217-782-4515

Or

IDOI Consumer Division
122 S. Michigan Ave., 19th Floor
Chicago, Illinois 60603
1-312-814-2420
web: *http://insurance.Illinois.gov*

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. Send a written appeal request to: The Claim Administrator Claim Review Section P.O. Box 2401 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 may file a Complaint with the Illinois Department of Insurance. The Illinois Department of Insurance will notify the Claim Administrator of the Complaint. The Claim Administrator will have 21 days to respond to the Illinois Department of Insurance.

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.

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 Claim Administrator immediately must 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 Providers work, please consider the following example:

a. Assume you go into the Hospital for one night and the normal, full amount the Hospital bills for Covered Services is $1,000. How is the $1,000 bill paid?

b. You personally will have to pay the deductible and Coinsurance amounts set out in 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.

INTER-PLAN ARRANGEMENTS

I. Out-of-Area Services

Overview

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

When you receive care outside of the Claim Administrator's service area, you will receive it from one of two kinds of Providers. Most Providers

("participating Providers") contract with the local Blue Cross and/or Blue Shield Licensee in that geographic area ("Host Blue"). Some Providers ("nonparticipating Providers") do not contract with the Host Blue. The Claim Administrator explains below how the Claim Administrator pays both kinds of Providers.

Inter-Plan Arrangements Eligibility – Claim Types

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

A. BlueCard® Program

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

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

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

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

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

a. Suppose you receive Covered Services for an illness while you are on vacation 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 state laws or regulations may require a surcharge, tax or other fee that applies to self-funded accounts. If applicable, the Claim Administrator will include any such surcharge, tax or other fee as part of the Claim Charge passed on to you.

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

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 the 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:

(i) 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

(ii) 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.

- **Inpatient Services**

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

- **Outpatient Services**

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

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

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

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.

2. THE CLAIM ADMINISTRATOR'S SEPARATE FINANCIAL ARRANGEMENTS REGARDING PRESCRIPTION DRUGS

Claim Administrator's Separate Financial Arrangements with Prescription Drug Providers

The Claim Administrator hereby informs you that it has contracts, either directly or indirectly, with Prescription Drug Providers ("Participating Prescription Drug Providers") to provide prescription drug services to all persons entitled to prescription drug benefits under health policies and contracts to which the Claim Administrator is a party, including all persons covered under this Health Care Plan. Under its contracts with Participating Prescription Drug Providers, the Claim Administrator may receive from these Providers discounts for prescription drugs dispensed to you. Actual discounts used to calculate your share of the cost of prescription drugs will vary. Some discounts are currently based on Average Wholesale Price ("AWP") which is determined by a third party and is subject to change. You understand that the Claim Administrator may receive such discounts. Neither the Employer nor you are entitled to receive any portion of any such payments, discounts and/or other allowances.

Coinsurance amounts payable by you under this Health Care Plan will be calculated on the basis of the Provider's Eligible Charge or the agreed upon cost between the Participating Prescription Drug Provider and the Claim Administrator for a prescription drug, whichever is lower.

To help you understand how the Claim Administrator's separate financial arrangements with Prescription Drug Providers work, please consider the following example:

a. Assume you have a prescription dispensed and the normal, full amount of the prescription drug is $100. How is the $100 bill paid?

b. You personally will have to pay the Coinsurance amount set out in this benefit booklet.

c. However, for purposes of calculating your Coinsurance amount, the full amount of the prescription drug would be reduced by the discount. In our example, if the applicable discount were 20%, the $100 prescription drug bill would be reduced by 20% to $80 for purposes of calculating your Coinsurance amount.

d. In our example, if your Coinsurance obligation is 25%, you personally will have to pay 25% of $80, or $20. You should note that your 25% Coinsurance is based upon the discounted amount of the prescription and not the full $100 bill.

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

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

The amounts received by Prime from the Claim Administrator, Pharmacies, manufacturers or other third parties may be revised from time to time. Some of the amounts received by Prime may be charged each time a Claim is processed (or, in some instances, requested to be processed) through Prime and/or each time a prescription is filled, and include, but are not limited to, administrative fees charged by Prime to the Claim Administrator (as described above), administrative fees charge by Prime to Pharmacies and administrative fees charged by prime to pharmaceutical manufacturers. Currently, none of these fees will be passed on to you as expenses, or accrue to the benefit of you, unless otherwise specifically set forth in this benefit booklet. Additional information about these types of fees or the amount of these fees is available upon request. As of the effective date, the maximum that a PBM has disclosed to the Claim Administrator that the PBM will receive from any pharmaceutical manufacturer for manufacturer administrative fees is five and a half percent (5.5%) of the Wholesale Acquisition Cost ("WAC") for all products of such manufacturer dispensed during any given calendar year to members of the Claim Administrator and to members of the other Blue Cross and/or Blue Shield operating divisions of Health Care Service Corporation or for which Claims are submitted to the PBM at the Claim Administrator's request; provided, however, that the Claim Administrator will advise the Employer if such maximum has changed.

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.

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 anytime 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 or group administrator information regarding your or your dependents becoming eligible for Medicare, termination of Medicare eligibility or any changes in Medicare eligibility status in order that the Claim Administrator be able to make Claim Payments in accordance with MSP laws.

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.

10. IDENTITY THEFT PROTECTION SERVICES

The Claim Administrator makes available at no additional cost to you identity theft protection services, including credit monitoring, fraud detection, credit/identity repair and insurance to help protect your information. These identity theft protection services are currently provided by the Claim Administrator's designated outside vendor and acceptance or declination of these services is optional to you. If you wish to accept such identity theft protection services you will need to individually enroll in the program online at *www.bcbsil.com* or telephonically by calling the toll-free telephone number on your identification card. Services may automatically end if you no longer meet the definition of an Eligible Person. Services may change or be discontinued at any time with or without notice and the Claim Administrator does not guarantee that a particular vendor or service will be available at any given time. The services are provided as a convenience and are not considered covered benefits under this benefit booklet.

REIMBURSEMENT PROVISION

If you or one of your covered dependents incur expenses for sickness or injury that occurred due to negligence of a third party and benefits are provided for Covered Services described in this benefit booklet, you agree:

a. the Claim Administrator has the rights to reimbursement for all benefits the Claim Administrator provided from any and all damages collected from the third party for those same expenses whether by action at law, settlement, or compromise, by you or your legal representative as a result of sickness or injury, in the amount of the total Eligible Charge or Provider's Claim Charge for Covered Services for which the Claim Administrator has provided benefits to you, reduced by any Average Discount Percentage ("ADP") applicable to your Claim or Claims.

b. the Claim Administrator is assigned the right to recover from the third party, or his or her insurer, to the extent of the benefits the Claim Administrator provided for that sickness or injury.

The Claim Administrator shall have the right to first reimbursement out of all funds you, your covered dependents or your legal representative, are or were able to obtain for the same expenses for which the Claim Administrator has provided benefits as a result of that sickness or injury.

You are required to furnish any information or assistance or provide any documents that the Claim Administrator may reasonably require in order to obtain our rights under this provision. This provision applies whether or not the third party admits liability. (See provisions of this benefit booklet regarding "Claim Administrator's Separate Financial Arrangements with Providers.")

Administered by:

BlueCross BlueShield of Illinois

Experience. Wellness. Everywhere.℠

ASO-1

Effective Date: January 1, 2020

www.bcbsil.com

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

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

C.P. v. Blue Cross Blue Shield of Illinois
USDC (W.D. Wash.), No. 3:20-cv-06145-RJB

CONFIDENTIAL EXHIBIT

Filed Under Seal
Pursuant to Protective Order (Dkt. No. 25)

Exhibit I

UNITED STATES DISTRICT COURT

WESTERN DISTRICT OF WASHINGTON

AT TACOMA

C.P., by and through his parents, Patricia Pritchard and Nolle Pritchard and PATRICIA PRITCHARD, Plaintiffs,	)	
vs.	)	No. 3:20-cv-06145-RJB
BLUE CROSS BLUE SHIELD OF ILLINOIS, Defendant.	)	

ZOOM VIDEO DEPOSITION UPON ORAL EXAMINATION

OF

LAURA MALEC, 30(b)(6)

9:30 a.m.

August 19, 2022

REPORTED BY: Pat Lessard, CCR #2104

it.

Q. All right. And how did Blue Cross Blue Shield of Illinois identify the denials that it looked at to evaluate the list?

MS. PAYTON: Object to the form of the question.

A. Denial, so it's in our records or we went back and looked at where a denial was. So we looked in our systems and did a search on denials with this type of a category on it.

Q. (By Ms. Hamburger) So I'm trying to drill down on that.

Did you look for denials that had a particular diagnostic code or treatment code? How did they find the denials?

A. It would be a type of denial. I'm not exactly sure what it's called but is it a, you know, a gender exclusion or a gender service, you know, type of a benefit that was then denied.

Q. But you don't know how they identified the denials specifically, is that right?

MS. PAYTON: Object to the form.

A. I don't do claim denials. That's not a team that I manage, so I don't want to speak to that.

MS. PAYTON: Can we take a five-minute

break?

MS. HAMBURGER: Sure.

MS. PAYTON: Okay.

THE VIDEOGRAPHER: We're going off the record at 9:57 a.m.

(Recess.)

THE VIDEOGRAPHER: One moment, please. We're back on the record at 10:01 a.m.

A. So I believe I'm understanding your question better. If you would reask your question or if we could reask it then I think I could answer it in a better way.

MS. HAMBURGER: Pat, would you mind reading it back?

THE REPORTER: "Question. But you don't know how they identified the denials specifically, is that right?"

A. I do understand the analysis that was done. Our legal team went in and looked at anything with a gender dysphoria diagnosis.

And what were they doing was looking at anything there that had been denied based on exclusion in a plan.

And they did the matching of those and went in and looked at, you know, matched the denial back to

the plan to make sure that there had been an exclusion in the plan and we had actually denied that properly.

Q. (By Ms. Hamburger) Okay. So they looked at denials of services that had a gender dysphoria diagnosis, is that right?

A. Yes.

Q. All right. And did this review that was done, it covered only Blue Cross Blue Shield of Illinois administered self-funded plans, is that right?

A. Yes.

Q. And it reviewed plans regardless of the specific geographic location of the members?

A. Yes.

Q. Okay. Is it fair to say that most of those plans were located in the state of Illinois?

A. The plans would be, I believe the term would be sited out of Illinois.

Q. Okay. But their employees could be located anywhere, is that right?

A. Yes.

Q. Okay. And indeed some of the employees are located across the country, is that right?

A. Sure.

Q. Blue Cross Blue Shield of Illinois would

administer plans with members beyond the state line of Illinois, is that right?

A. Yes.

Q. I want to turn to the first topic 1.a. in the deposition notice. And that asks for the number of self-funded ERISA plans administered by Blue Cross Blue Shield of Illinois that contain gender affirming care exclusions that have the language that is the same or similar to the exclusions listed in Addendum A.

Do you see that?

A. I do.

Q. Okay. And I have numbered Exhibit 46, which is the Addendum A, numbering from page 13, the very first exclusion, numbering them -- I think it's one through 18 or something.

And I can put my copy up on the screen or we could -- I understand your counsel may have handwritten the numbers in.

A. Yes.

Q. Which is easier for you? Should I put it on the screen or are you just going to read off the handwritten copy that you have?

A. The copy I have is fine.

Q. Okay. So the first one it says "Effective

Date 1/01/2017," and it says "Gender reassignment Surgery (also referred to as transsexual Surgery, sex reassignment Surgery or intersex Surgery) including related services and supplies."

Do you see that?

A. I do.

Q. Okay. And does that reflect one kind of exclusion that appears in the self-funded group health plans administered by Blue Cross Blue Shield of Illinois?

A. Yes.

Q. Okay. And how many plans have that language?

A. 378.

Q. Okay. Now previously we had been told that number one was the standard language when a Blue Cross Blue Shield of Illinois plan -- standard language that Blue Cross Blue Shield of Illinois offers to employers when they want a gender affirming care exclusion.

Is that your understanding?

A. It is.

Q. So let's turn to number two. This one is dated 1/1/2019.

Do you see that?

A. I do.

Q. I'm not going to read it because it's too long.

But how many plans have number two?

A. One.

Q. Okay. Let's turn to number three. That one is dated 1/01/2020.

How many plans have that one?

A. One. For each of the next, if I may, two through 17 are each represented uniquely in one plan.

Q. Okay. Thank you. And what about 18 and 19?

A. I didn't see them on the back. They are uniquely identified as well.

Q. Okay.

A. So through 19 are uniquely identified as one plan as well.

Q. Okay. And then on 18, if you could take a look at it, it uses an abbreviation FFL in three places.

Do you know what that refers to?

A. I do not but I'm happy to follow up.

Q. Okay. Thank you. I appreciate that.

And does this Addendum A represent the universe of Blue Cross Blue Shield of Illinois ERISA self-funded plans that have gender affirming care exclusions to the best of Blue Cross Blue Shield of

Illinois's knowledge?

A. To the best of my knowledge, yes.

Q. Okay. So let's turn to 1.c in the Notice of Deposition, "Whether Blue Cross Blue Shield of Illinois requires ERISA self-funded plans to have any legal basis, or medical, scientific, or other justification for the gender affirming care exclusion before Blue Cross Blue Shield of Illinois will implement it."

So does Blue Cross Blue Shield of Illinois require its self-funded plans to provide a reason for their decision to exclude gender affirming care?

A. No.

Q. The decision to exclude gender affirming care can just be the individual preference of the employer plan?

A. Yes.

Q. And it could just be an arbitrary decision?

A. Yes.

Q. Does Blue Cross Blue Shield of Illinois conduct any investigation for the reason for the gender affirming care exclusion?

A. No.

Q. Blue Cross Blue Shield of Illinois would agree to administer a gender affirming care exclusion

without any consideration of the reason why the employer wanted to impose the exclusion?

A. Yes.

Q. Okay. It wouldn't matter to Blue Cross Blue Shield of Illinois if the employer had a discriminatory reason for the exclusion?

MS. PAYTON: I'm going to object to the form of the question.

Q. (By Ms. Hamburger) Do you know?

A. No.

Q. Blue Cross Blue Shield of Illinois would administer it even if the employer wanted the exclusion due to discrimination?

MS. PAYTON: Object to the form of the question. Asked and answered.

A. Yes.

Q. (By Ms. Hamburger) So to sum up, Blue Cross Blue Shield of Illinois does not require its self-funded plans to have any legal basis for implementation of a gender affirming care exclusion before Blue Cross Blue Shield of Illinois will implement it?

MS. PAYTON: Object to the form. Asked and answered.

A. No.

compliance with the law?

A. Are you talking about for self insured?

Q. Correct.

A. No. It wouldn't be under the scope of that workgroup.

Q. And so the Section 1557 workgroup never reviewed or approved the gender affirming care exclusions that Blue Cross Blue Shield of Illinois was asked to administer for self-funded groups?

MS. PAYTON: Object to the form.

A. Not that I'm aware.

Q. (By Ms. Hamburger) And I'm asking you here on behalf of Blue Cross Blue Shield of Illinois, not your personal awareness.

A. No.

Q. Okay. Turning to 1.f. and referencing the plans that we discussed in Addendum A.

In those plans in Addendum A, do they generally cover mastectomies for conditions other than gender dysphoria when medically necessary?

MS. PAYTON: I'm going to object to the form of the question and the scope. We already presented a witness on this issue.

But go ahead and answer.

A. So can you repeat the question?

MS. HAMBURGER: Pat?

THE REPORTER: "Question. In those plans in Addendum A, do they generally cover mastectomies for conditions other than gender dysphoria when medically necessary?"

MS. PAYTON: Same objection.

A. Yes. If it is not listed as an exclusion and they are using our medical policy, and something is medically necessary, it is often approved or it would be approved.

Q. (By Ms. Hamburger) Are you aware of any of these plans having an exclusion, a specific exclusion for mastectomies?

A. No.

Q. In the plans that included gender affirming care do those plans generally cover hormone therapy for other conditions?

A. When medically necessary.

MS. PAYTON: Same objection.

Ele, can I have a standing objection so I'm not interrupting your flow?

MS. HAMBURGER: Sure.

MS. PAYTON: Okay. It's a standing objection to the scope and the fact that the medical issues should have been asked of Dr. Reed, so I'm

going to stop making the objection.

Go ahead and answer.

A. Can you just repeat the question then?

Q. (By Ms. Hamburger) In the plans that include gender affirming care that are identified in Addendum A do those plans generally cover hormone therapy for other conditions than gender affirming -- than gender dysphoria when medically necessary?

A. Yes.

Q. In those plans that exclude gender affirming care in Addendum A, do those plans generally cover hysterectomies when medically necessary for conditions other than gender dysphoria?

A. Yes.

Q. In those plans that exclude gender affirming care in Addendum A, do those plans generally cover chest reconstruction surgery for conditions other than gender dysphoria when medically necessary?

A. Yes.

Q. How does Blue Cross Blue Shield know when to cover a mastectomy in one of the plans identified in Addendum A and when to exclude it?

MS. PAYTON: Object to the form. Way outside the scope.

A. We match the plan design which is done by

MS. PAYTON: Object to the form.

A. I don't know what happened when the denials happened.

Q. (By Ms. Hamburger) I believe you testified earlier that the denials that Blue Cross Blue Shield of Illinois pulled to determine which plans had gender-affirming exclusions all had a diagnostic code of gender dysphoria, is that right?

A. Yes. We did do that pull and that's how we got to our lists.

Q. Okay. And turning again to 1.f., which again asks for under what conditions each of the self-funded plans cover the same or similar treatment when medically necessary for other conditions.

Do you see that question in 1.f.?

A. Yes.

Q. Okay. Is the condition that triggers the application of the gender affirming care exclusion gender dysphoria?

MS. PAYTON: Object to the form. Asked and answered, scope.

A. Yes.

MS. HAMBURGER: Okay. I'm going to take a five-minute break.

MS. PAYTON: Okay.

C.P. v. Blue Cross Blue Shield of Illinois
USDC (W.D. Wash.), No. 3:20-cv-06145-RJB

CONFIDENTIAL EXHIBIT

Filed Under Seal
Pursuant to Protective Order (Dkt. No. 25)

Exhibit L

BlueCross BlueShield of Illinois

93462306469

Medical Policies

Medical Policies - Surgery

Print

Gender Assignment Surgery and Gender Reassignment Surgery with Related Services

Number: SUR717.001

Effective Date: 05-01-2019

Coverage:

CAREFULLY CHECK STATE REGULATIONS AND/OR THE MEMBER CONTRACT

Gender Assignment Surgery

Gender assignment surgery for patients with ambiguous genitalia diagnosed at birth or in infancy **is considered reconstructive surgery and may be considered medically necessary.**

Gender Reassignment Surgery

NOTE: State Legislation may apply. Carefully check for legislative mandates that may apply for each plan.

ILLINOIS Legislative Mandate: 50 Illinois. Administrative. Code 2603.35 provides that a group health insurance plan that is neither a grandfathered plan nor a plan offering excepted benefits shall not discriminate on the basis of an insured's or prospective insured's actual or perceived gender identity, or on the basis that the insured or prospective insured is a transgender person.

Pursuant to the above, Gender Reassignment Surgery would be a covered benefit for Illinois insured policies subject to the coverage criteria set forth below.

CAREFULLY REVIEW the member's benefit contract for gender reassignment surgery and related services provisions. If there is a discrepancy between this medical policy and the member's benefit contract, the contract will govern.

Gender reassignment surgery -- also known as transsexual surgery or sex reassignment surgery -- and related services **may be considered medically necessary when meeting the criteria for gender dysphoria listed below.**

Otherwise, gender reassignment surgery and related services **will be considered not medically necessary.**

Criteria for Coverage of Gender Reassignment Surgery and Related Services: 93462306469

The individual being considered for surgery and related services must meet ALL the following criteria. The individual **must have**:

• Reached the age of majority; **AND**

• The capacity to make a fully informed decision and to consent for treatment; **AND (ALERT -** For Gender Reassignment Surgery and Related Services for Children and Adolescents within this coverage, **proceed down** through this coverage section to the area **following NOTE 4.)**

• Been diagnosed with persistent, well-documented gender dysphoria; **AND**

• The required referrals prior to any surgery or related service(s):

o Prior to feminizing or masculinizing hormonal therapy, one required referral from the individual's qualified mental health professionals (see **NOTE 1** below) competent in the assessment and treatment of gender dysphoria; **and/or**

o Prior to breast/chest surgery, e.g., mastectomy, chest reconstruction, or breast augmentation, one required referral from the individual's qualified mental health professionals (see **NOTE 1** below) competent in the assessment and treatment of gender dysphoria; **and/or**

o Prior to any genital surgery, e.g., hysterectomy, salpingo-oophorectomy, orchiectomy, and/or other genital reconstructive procedures, two separate required independent referrals (or one signed by both referring providers) from the individual's qualified mental health professionals (see **NOTE 1** below) competent in the assessment, treatment of gender dysphoria, and addressing the identical/same surgery to be performed.

NOTE 1: Psychotherapy and Mental Health Services:

Psychotherapy is not required for gender reassignment services except when a mental health professional recommends psychotherapy based on initial assessment prior to gender reassignment surgery. The recommendation for psychotherapy must specify the goals of treatment along with estimates of the frequency and duration of therapy throughout the individual's experience living in one's affirmed gender. Review the criteria above under "Criteria for Coverage of Gender Reassignment Surgery and Related Services" for required surgical referral letters from qualified mental health professionals.

Pharmaceutical Gender Reassignment Services:

Continuous hormone replacement therapy **may be considered medically necessary** prior to gender reassignment of either male-to-female (MtF) or female-to-male (FtM) surgical services **OR** following gender reassignment MtF or FtM surgical services.

Continuous hormone replacement therapy may include the following services:

• Hormone injections by the medical provider, such as during an office visit; and/or

• Self-administered oral and injectables obtained from a pharmacy.

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NOTE 2: It is not uncommon for an individual to receive continuous hormone replacement therapy for 12-months or more.

Pharmaceutical agents to treat hair loss or growth, sexual performance post-gender reassignment genital surgery (e.g., Viagra or Cialis), and/or cosmetic enhancements, including collagen and/or botulinum toxin injections, **are considered not medically necessary.**

Gender Reassignment Laboratory Services:

Laboratory testing to monitor continuous hormonal replacement therapy for treatment of gender dysphoria **may be considered medically necessary**.

Primary Sexual Characteristic Gender Reassignment Chest and/or Genital Surgeries:

Male-to-Female (MtF) surgical procedures performed as part of gender reassignment services for an individual who has met the above criteria for gender dysphoria **may be considered medically necessary** and include the following:

• Breast modification, including but not limited to breast enlargement, breast augmentation, mastopexy, implant insertion, and silicone injections, and nipple or areola reconstruction;

• Clitoroplasty;

• Coloproctostomy;

• Colovaginoplasty;

• Labioplasty;

• Orchiectomy;

• Penectomy;

• Penile skin inversion;

• Repair of introitus;

• Vaginoplasty with construction of vagina with graft; and/or

• Vulvoplasty.

Female-to-Male (FtM) surgical procedures performed as part of gender reassignment services for an individual who has met the above criteria for gender dysphoria **may be considered medically necessary** and include the following:

• Hysterectomy;

• Metoidioplasty;

• Phalloplasty;

• Placement of an implantable erectile prostheses;

• Placement of testicular prostheses;

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• Salpingo-oophorectomy;

• Scrotoplasty;

• Subcutaneous mastectomy, including nipple or areola reconstruction;

• Vaginectomy (colpectomy);

• Urethroplasty; and/or

• Urethromeatoplasty.

Secondary Sexual Characteristic (Masculinizing or Feminizing) Gender Reassignment Surgeries and Related Services:

Procedures or services to create and maintain gender specific characteristics (masculinization or feminization) as part of the overall desired gender reassignment services treatment plan **may be considered medically necessary for the treatment of gender dysphoria ONLY.** These procedures may include the following:

• Abdominoplasty;

• Blepharoplasty;

• Brow lift;

• Calf implants;

• Cheek implants;

• Chin or nose implants;

• External penile prosthesis (vacuum erection devices);

• Face lift (rhytidectomy);

• Facial bone reconstruction/sculpturing/reduction, includes jaw shortening;

• Forehead lift or contouring;

• Hair removal (may include donor skin sites) or hair transplantation (electrolysis or hairplasty);

• Laryngoplasty;

• Lip reduction or lip enhancement;

• Liposuction/lipofilling or body contouring or modeling of waist, buttocks, hips, and thighs reduction;

• Neck tightening;

• Pectoral implants;

• Reduction thyroid chondroplasty or trachea shaving (reduction of Adam's apple);

• Redundant/excessive skin removal;

- Rhinoplasty (nose correction);

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- Skin resurfacing;

- Testicular expanders;

- Voice modification surgery; and/or

- Voice (speech) therapy or voice lessons.

NOTE 3: Preparatory or ancillary procedures (such as anesthesia, tissue harvesting for skin, fat, nerve or muscle grafting, etc.) and supplies or equipment (such as stents, prosthesis, implants, etc.) that are required for the procedures listed above are considered an integral part of the MtF or FtM transition process.

NOTE 4: Surgical repairs or revisions related to MtF or FtM procedures may be required, such as removal and replacement of prostheses.

Gender Reassignment Surgery and Related Services for Children and Adolescents:

The following services **may be considered medically necessary** for the treatment of gender dysphoria for children and adolescents:

- Hormone therapy (such as, puberty-suppressing hormones or masculinizing/feminizing hormones);

- Psychological services, including but not limited to psychotherapy, social therapy, and family counseling; and/or

- Chest surgery for FtM individuals.

NOTE 5: The 2012 World Professional Association for Transgender Health (WPATH) Standards of Care (SOC) (6) state the following regarding adolescent individuals seeking irreversible interventions, such as genital surgery:

"Genital surgery should not be carried out until (i) patients reach the legal age of majority to give consent for medical procedures in a given country, and (ii) patients have lived continuously for at least 12 months in the gender role that is congruent with the gender identity. The age threshold should be seen as a minimum criterion and not an indication in and of itself for active intervention."

Gender Primary or Secondary Sexual Characteristic Revision Surgeries

When there is documented evidence of physical functional impairment, gender primary or secondary sexual characteristic revision procedures or services **are considered medically necessary**.

When there is no documented evidence of physical functional impairment, gender primary or secondary sexual characteristics revision services **are considered not medically necessary** (refer to appropriate procedure-specific policy).

Preventive Medicine Gender Reassignment Services:

Preventive medicine services **considered medically necessary in conjunction with gender reassignment services include**:

- Breast cancer screening for FtM individuals; or
- Cervical cancer screening for FtM individuals; or
- Prostate cancer screening for MtF individuals; or
- Contraception pharmaceuticals for FtM individuals at risk of pregnancy.

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Gender Reassignment Reproductive Services:

Procurement, cryopreservation/freezing, storage/banking, and thawing of reproductive tissues, such as oocytes, ovaries, embryos, spermatozoa, and testicular tissue **may be considered medically necessary for individuals with gender dysphoria because** gender reassignment services, such as long-term cross-sex hormone therapy or surgical procedures, may render an individual infertile whether or not the individual has reproduced in the past.

Reversal of Gender Reassignment Surgical Procedures

For reversal of any of the prior gender reassignment surgical procedure(s) or service(s) for gender primary or secondary sexual characteristics, the patient **must meet the same criteria for gender dysphoria** to have those reversal procedures **considered medically necessary**.

If the criteria for gender dysphoria is not met, then reversal of any prior gender reassignment surgical procedure(s) or service(s) for gender primary or secondary sexual characteristics **is considered not medically necessary.**

Description:

Gender Assignment Surgery

Gender assignment surgery (GAS), also known as genitoplasty, is genital reconstruction of ambiguous genitalia in newborns or infants difficult to classify as a male or female. The extent of the ambiguity varies. In very rare instances, the physical appearance may be fully developed as the opposite of the genetic sex (e.g., a genetic male may have developed the appearance of a typical female). (1) To the lay person the determination of an infant's sex can easily be identified as male or female, by virtue of outward genital anatomy, secondary sexual characteristics and behavior within their relevant cultural context. Arriving at a satisfactory scientific definition is more difficult as gender reflects the outcome of complex interactions occurring from the time of conception and extending throughout pre- and postnatal life. (2)

Intersex anomalies associated with ambiguous genitalia may result from major chromosomal abnormalities or from specific gene mutations as in congenital adrenal hyperplasia. (2) Typically, the ambiguous genitalia in genetic females (babies with two X chromosomes) include an enlarged clitoris that has the appearance of a small penis. The urethral opening can be anywhere along, above, or below the surface of the clitoris. The labia may be fused, resembling a scrotum. The infant may be thought to be a male with undescended testicles. Sometimes a lump of tissue is felt within the fused labia, further making it look like a scrotum with testicles. (3, 4)

In a genetic male (babies with one X and one Y chromosome), the ambiguous genitalia typically include a small penis (less than 2-3 centimeters or 0.8-1.2 inches) that may appear to be an enlarged clitoris (the clitoris of a

newborn female is normally somewhat enlarged at birth). The urethral opening may be anywhere along, above, or below the penis; it may be placed as low as on the peritoneum, further making the infant appear to be female. There may be a small scrotum with any degree of separation, resembling labia. Undescended testicles commonly accompany ambiguous genitalia. (3, 4)

Disorders which include ambiguous genitalia, which are usually not life threatening, have serious and potentially lifelong consequences for the affected child and, depending on the underlying cause, are likely to entail surgery in childhood and in later life, for example endocrine replacement therapy in conjunction with steroid replacement for those with congenital adrenal hyperplasia. (1) Making a correct determination of gender is both important for treatment purposes, as well as the emotional well-being of the child. Some children born with ambiguous genitalia may have normal internal reproductive organs. However, others may experience health issues from an underlying cause of the disorder. A list of the most common causes is listed below:

• Pseudohermaphroditism, the genitalia are of one sex, but some physical characteristics of the other sex are present.

• True hermaphrodism, a very rare condition in which both ovarian and testicular tissue is present. The child may have parts of both male and female genitalia.

• Mixed gonadal dysgenesis, an intersex condition in which there appears some male structures (gonads, testis), as well as a uterus, vagina, and fallopian tubes.

• Congenital adrenal hyperplasia, a potentially life-threatening condition, has several forms, but the most common form causes the genetic female to appear male.

• Chromosomal abnormalities, including Klinefelter's syndrome (XXY) and Turner's syndrome (XO).

• Maternal ingestion of certain medications (including androgenic steroids) may cause a genetic female to look more male.

• Lack of production of specific hormones can cause the embryo to develop with a female body type regardless of genetic sex, such as the lack of testosterone cellular receptors. (1)

Regulatory Status

Gender assignment surgical procedures are surgical interventions and, as such, are not subject to regulation by the U.S. Food and Drug Administration (FDA).

Gender Reassignment Surgery

Gender dysphoria (formerly known as 'gender identity disorder') is a condition recognized by the Diagnostic and Statistical Manual (DSM) of Mental Disorders and commonly known as transsexualism. (5) The diagnostic criteria describe many individuals who experience dissonance between their sex at

birth and personal gender identity, which is not the same as having ambiguous genitalia. According to the American Academy of Pediatrics, based on population surveys completed in 2014 of 17 states, it suggested that the number of adults who identify as "gender non-conforming" or transgender is 0.6% (1.4 million). (7) On the basis of that data, it is estimated that 0.7% of youth, ages 13 to 17 years (~150,000) identify as transgender. 9346280469

Gender reassignment surgery (GRS) is also known as sex reassignment surgery; genital reconstruction surgery; sex affirmation surgery; sex realignment surgery; intersex surgery, or sex-change operation. It is a term used for the culmination of a series of surgical procedures and treatments by which a person's physical appearance and the function(s) of existing sexual characteristics are altered or even irreversibly changed to that of the opposite sex. Gender reassignment generally consists of several treatment plans, which include the diagnostic phase (mostly supported through mental health professional interaction) followed by continuous hormonal therapy (through an endocrinologist). It includes living openly in a manner consistent with the affirmed gender or completed with the GRS itself. (5)

Other terms are used to describe these procedures. These include sex reconstruction surgery; gender confirmation surgery; feminizing genitoplasty or penectomy, orchidectomy and vaginoplasty for trans women, with masculinizing genitoplasty or phalloplasty for trans men. (Definitions of these procedures can be found later in this Description section.) These procedures and services are used to treat individuals diagnosed with gender dysphoria in transsexual or transgender people. (1, 2, 6)

Guidelines for GRS and related services have been developed by the World Professional Association for Transgender Health (WPATH) (1), formerly known as the Harry Benjamin International Gender Dysphoria Association. WPATH is an international, multispecialty, professional association whose mission is to promote evidence-based care, education, research, advocacy, public policy, and respect for transgender health. In May 2010, WPATH urged de-psychopathologization of gender nonconformity worldwide by stating, "The expression of gender characteristics, including identities, that are not stereotypically associated with one's assigned sex at birth is a common culturally-diverse human phenomenon [that] should not be judged as inherently pathological or negative." WPATH clarified the related procedures and services when an individual is considering surgical transformation from male-to-female (MtF) or female-to-male (FtM), as well as how the treatment differs for gender dysphoria and transsexualism. (1)

- WPATH Standards of Care (SOC)

The WPATH SOC document provides an overview of surgical procedures to treat patients with gender dysphoria, otherwise known as gender affirming surgeries. (6, 7)

"For the MtF (male-to-female) patient, surgical procedures may include the following:

1. Breast/chest surgery: augmentation mammoplasty (implants/lipofilling);

2. Genital surgery: penectomy, orchiectomy, vaginoplasty, clitoroplasty, vulvoplasty;

3. Non-genital, non-breast surgical interventions: facial feminization surgery, liposuction, lipofilling, voice surgery, thyroid cartilage reduction, breast augmentation (implants/lipofilling), hair reconstruction, and various aesthetic procedures."

"For the FtM (female-to-male) patient, surgical procedures may include to following:

1. Breast/chest surgery: subcutaneous mastectomy, creation of male chest;

2. Genital surgery: hysterectomy/salpingo-oophorectomy, reconstruction of the fixed part of the urethra, which can be combined with a metoidioplasty or with a phalloplasty (employing a pedicle or free vascularized flap), vaginectomy, scrotoplasty, and implantation of erection and/or testicular prostheses;

3. Non-genital, non-breast surgical interventions: voice surgery (rare), liposuction, lipofilling, pectoral implants, and various aesthetic procedures."

SOC criteria for surgical services were introduced as a guide to decision making for breast/chest and genital surgery. (6) However, the SOC does not include criteria for other surgical procedures, such as masculinizing or feminizing facial surgery. The SOC does not stipulate the number, sequence, and/or timing of surgical procedures because they will vary from patient to patient, according to an individual patient's clinical needs and expectations, in collaboration with mental health and surgical professionals. (6)

Terminology in Relationship to Gender Reassignment Surgery and Related Services

Health care terminology for transsexual, transgender, and gender nonconforming individuals is rapidly evolving; new terms are being introduced and definitions of existing terms are changing. This tends to create misunderstanding, debate, or disagreement about the language used in this field.

For the purposes of this policy document, we have defined terms that may be unfamiliar or that have specific meanings in the "SOC." Although others may adopt these definitions, WPATH has acknowledged that the terms they use may be defined differently in different cultures, communities, and contexts. (1)

• Affirmed gender is when an individual's true gender identity, or concern about their gender identity, is communicated to and validated from others as authentic. (7)

• Agender is an individual who does not identify as having a particular gender. (7)

• Bioidentical hormones are structurally identical to those found in the human body and generally derived from plant sources. The hormones used in bioidentical hormone therapy (BHT) need to be commercially processed to become bioidentical. (6)

• Bioidentical compounded hormone therapy (BCHT) are prepared, mixed, assembled, packaged, or labeled as a drug by a pharmacist and custom-made for an individual according to a physician's specifications. (6)

• Cisgender or cissexual describes related types of gender identity perceptions, where the individuals' experiences of their own gender are in accordance with the sex they were assigned at birth. Cisgender may be a complement to transgender. (6)

• Cross-sex hormone therapy, transgender hormone therapy or medical affirmation refers to a form of hormone replacement therapy in which sex hormones and other hormonal medications are administered for the purpose of more closely aligning with the individual's secondary sexual characteristics. (7)

• Disorders of sex development are the congenital conditions in which the development of chromosomal, gonadal, or anatomic sex is atypical. Some people strongly object to the "disorder" label and instead view these conditions as a matter of diversity (1), preferring the terms intersex and intersexuality.

• Female-to-Male (FtM) describes individuals assigned female at birth who are changing or who have changed their body and/or gender role from birth-assigned female to a more masculine body or role. (6)

• Feminizing hormone therapy for transgender women or transfeminine individuals consists of estrogens and antiandrogens/androgen inhibitor. (7)

• Gender diverse is an umbrella term to describe an ever-evolving array of labels that individuals may apply when their gender identity, expression, or even perception does not conform to the norms and stereotypes others expects of their assigned sex. (7)

• Gender dysphoria, formerly known as gender identity disorder, is characterized by strong persistent cross-gender identification or a discrepancy between with the continuous discomfort or distress about one's anatomic sex (person's sex assigned at birth) or, by a sense of inappropriateness in the gender role of that sex. (1, 2) This includes inappropriateness clinically causes impairment in social, occupational, or other important areas of functioning. (2)

• Gender identity is the intrinsic sense of knowing to which sex one belongs—that is the awareness that 'I am female" (a girl or woman), or "I am male" (a boy or a man). Gender identity is the private experience of gender role and gender role is the public expression of gender identity. Gender role can be defined as everything one says and does, including sexual arousal, to indicate to others or to oneself the degree to which one is male or female. Some individuals describe themselves not as gender-nonconforming, but as unambiguously cross-sexed or unique/transitional. Such individuals no longer consider themselves to be either male or female. An individual may never fully embrace the gender role they were assigned at birth or an individual may actualize their gender identity, role, and expression in a way that does not involve a change from one gender to another gender. (1, 6) Gender identity and sexual orientation (see below) are distinct but interrelated constructs. Therefore, being transgender does not imply a sexual orientation, and individuals who identify still identify as straight, gay, bisexual, etc., on the basis of their attractions. (7)

• Gender identity disorder is a psychiatric diagnosis defined previously in the DSM-IV (changed to "gender dysphoria" in the DSM-5). This is no longer appropriate for use and may lead to stigma, but the term may be found in older research. (7)

• Gender non-conforming is an adjective to describe individuals whose gender identity, role, or expression differs from what is normative for their assigned sex in a given culture and historical period or the individual differs from the cultural norms prescribed for people of a particular sex. (1)

• Gender role or expression are characteristics in personality, appearance, and behavior that in a given culture and historical period are designated as masculine or feminine (that is, more typical of the male or female social role). While most individuals present socially in clearly masculine or feminine gender roles, some people present in an alternative gender role such as "genderqueer" or specifically transgender. All people tend to incorporate both masculine and feminine characteristics in their gender expression in varying ways and to varying degrees. (1)

• Gender perception is the way others interpret an individual's gender expression. (7)

• "Genderqueer" is the identity label that may be used by individuals whose gender identity and/or role does not conform to a binary understanding of gender as limited to the categories of man or woman, male or female. (6)

• Genital phenotype is largely determined by androgenic stimulation of the external genitalia in embryonic and fetal life and depends on the presence of the appropriate receptors in the target tissues. (2)

• Gonadal phenotype is defined by the internal genitalia and the external morphology and microanatomy of the gonads (testis or ovary). (2)

• Hormones that express the sexual differentiation in humans include estrogens, progesterone, and androgens, such as testosterone. (6)

• Internalized transphobia describes the discomfort with one's own transgender feelings or identity as a result of internalizing society's normative gender expectations.

• Legal affirmation refers to the changing of gender and name recorded on birth certificate, school records, passports, and other documents. (7)

• Masculinizing hormone therapy for transgender men or transmasculine individuals consists of androgens, such as testosterone. (7)

• Male-to-Female (MtF) describes individuals assigned male at birth who are changing or who have changed their body and/or gender role from birth-assigned male to a more feminine body or role. (6)

• Natural hormones are derived from natural sources such as plants and animals. Natural hormones may or may not be bioidentical. (6)

• Puberty blockers are gonadotropin-releasing hormone (GnRH) analogues, such as leuprolide and histrelin. (7)

• Sex is assigned at birth as male or female, usually based on the appearance of the external genitalia, also known as "natal gender." When the external genitalia are ambiguous, other components of sex (internal genitalia, chromosomal and hormonal sex) are considered in order to assign sex. For most people, gender identity and expression are consistent with their sex assigned at birth; for transsexual, transgender, and gender nonconforming individuals, gender identity or expression differ from their sex assigned at birth. (1)

• Sexual characteristics are the physical and behavioral traits of an organism. In humans, sex organs or primary sexual characteristics are those an individual is born with. These traits are distinguished from secondary sex characteristics that develop later in life usually during puberty. The development of primary and secondary sexual characteristics is controlled by sex hormones produced in the body after the initial fetal stage, dependent on the presence or absence of the Y-chromosome and/or the testis-determining factor/gene to determine development. (6)

• Sexual orientation refers to an individual's identity relation to the gender(s) to which they are sexually and romantically attracted. (7)

• Social affirmation refers to adopting gender-affirming hairstyles, clothing, name, gender pronouns, and restrooms, including other facilities. (7)

• Surgical affirmation are the surgical/procedural approaches to feminize or masculinize physical features of an individual. (7)

• Transgender describes a diverse group of individuals who cross or transcend culturally-defined categories of gender. The gender identity of transgender people differs to varying degrees from the sex they were assigned at birth. (6)

• Transition is the period of time when individuals change from the gender role associated with their sex assigned at birth to a different gender role. For many people, this involves learning how to live socially in another gender role; for others this means finding a gender role and expression that is most comfortable for them. Transition may or may not include feminization or masculinization of the body through hormones or other medical procedures. The nature and duration of transition is variable and individualized. (1, 6)

• Trans men assume male gender identities. Trans men have an internal sense of being male and generally seek to make their maleness known socially and legally along with conforming their primary and secondary sex characteristics to a more typical male appearance. (1)

• Transsexualism is a gender dysphoria disorder in which the person manifests, with constant and persistent conviction, the desire to live as a member of the opposite sex and progressively takes steps to live in the opposite sex role full-time. These individuals who seek to change or who have changed their primary and/or secondary sex characteristics through feminizing or masculinizing medical interventions (hormones and/or surgery), typically accompanied by a permanent change in gender role. (2)

• Transvestism or cross-dressing describes the individual clothing and adopting a gender role presentation that, in a given culture, is of the other sex. (5)

• Trans women assume female gender identities. Trans women have an internal sense of being female and generally seek to make their femaleness known socially and legally along with conforming their primary and secondary sex characteristics to a more typical female appearance. (11)

Definitions of Irreversible Chest and Genital Surgical Procedures for Gender Reassignment

• Augmentation mammaplasty – insertion of breast implants or lipofilling (suctioning of body fat from one body area and filling into another body area) to create the female chest.

• Clitoroplasty – creation of a clitoris, utilizing the penile glans.

• Genitoplasty – genital reconstruction or modification of genitalia.

• Hysterectomy/salpingo-oophorectomy – removal of the uterus with or without ovaries and fallopian tubes.

• Metoidioplasty – following testosterone replacement therapy, the clitoris enlarges to be separated from the labia minora to create a penis.

• Orchiectomy – both testicles are removed.

• Penectomy – removal of the penis.

• Phalloplasty – construction or reconstruction of the penis.

• Reconstruction of the fixed part of the urethra – associated surgical reconstruction with the scrotoplasty to create a scrotal complex.

• Scrotoplasty – creation of a penis from external genitalia, such as the labia majora, with or without testicular prosthesis insertion or implant.

• Subcutaneous mastectomy – removal of breast tissue, sparing the nipple-areola complex to create the male chest.

• Vaginectomy – removal of part or the entire vagina.

• Vaginoplasty – construction or reconstruction of the vaginal canal and may include neovaginoplasty, the partial or total construction of the vulvo-vaginal complex.

• Vulvoplasty – a reduction of the labia and may be known as a labiaplasty.

Regulatory Status

Gender reassignment surgical procedures are surgical interventions and, as such, are not subject to regulation by the FDA. The devices and medications/combinations of medications used in the treatment of gender dysphoria are subject to FDA approval or clearance. Refer to the FDA web site at www.fda.gov for additional information on devices and medications that may be utilized for treatment.

Rationale:

This policy was originally created in 2006 and has updated regularly with searches of the MedLine database and the current World Professional Association for Transgender Health (WPATH) Standards of Care (SOC). The most recent literature search was performed through March 2019. The following is a summary of the key literature to date.

Gender Assignment Surgery

The ability to diagnose infants born with intersex conditions has advanced rapidly in recent years. In most cases today, clinicians can promptly make an accurate diagnosis and counsel parents on therapeutic options. However, the paradigm of early gender assignment has been challenged by the results of clinical and basic science research, which show that gender identity development likely begins in utero. While the techniques of surgical genital reconstruction have been mastered, the understanding of the psychological and social implications of gender assignment is poor. (1-3)

Treatment of ambiguous genitalia is controversial. No one debates the need to treat underlying physiologic problems such as those associated with congenital adrenal hyperplasia or tumors in the gonads. However, treatment for ambiguous genitalia depends on the type of disorder but will usually include corrective surgery to remove or create reproductive organs appropriate for the gender of the child. Treatment may also include hormone replacement therapy. Controversy revolves around issues of gender assignment by the physician and family which may not correlate with gender preference by the patient in adulthood. (1-4)

For example, Reilly and Woodhouse interviewed and examined 20 patients with the primary diagnosis of micropenis in infancy and concluded, "[A] small penis does not preclude a normal male role and a micropenis or microphallus alone should not dictate a female gender reassignment in infancy." More particularly, these doctors found that when parents "were well counseled about the diagnosis they reflected an attitude of concern but not anxiety about the problem, and they did not convey anxiety to their children. They were honest and explained problems to the child and encouraged normality in behavior. They believed that this is the attitude that allows these children to approach their peers with confidence. (2-4, 8)

From a medico-legal standpoint, the best approach to managing these cases is to provide parents with as much information as possible so that they can make informed decisions. Adequate counseling and support for parents is vital. The ideal management method is a team approach including neonatologists, geneticists, endocrinologists, surgeons, counselors, and ethicists. (2, 3, 9)

Ongoing and Unpublished Clinical Trials

A search of ClinicalTrials.gov in March 2019 did not identify any ongoing or unpublished trials that would likely influence this policy.

Professional Guidelines and Position Statements

There are no professional guidelines and position statements that would likely influence this policy. 93462306469

Section Summary: Gender Assignment Surgery

The available evidence supports the conclusion that psychological, medical, and/or surgical services are required for the treatment of ambiguous genitalia; therefore, considered medically necessary.

Gender Reassignment Surgery

Within the past decade, addressing transgender health care concerns has come to the forefront for inclusion and diversity worldwide. (10) These concerns have transcended to all facets of the lesbian, gay, bisexual, or transgender (LGBT) community, including initiating changes in the health care services offered to the transgender individuals.

In January 2016, ECRI published a special report on gender dysphoria. (12) Their review included 10 publications of systematic reviews and primary studies) targeting puberty suppression therapy, cross-sex hormonal therapy, and sexual reassignment surgery. The following is a summary of their reviews:

• *Puberty Suppression Therapy*: ECRI did not identify any studies that met their review inclusion criteria addressing this topic in the adolescent population.

• *Cross-Sex Hormonal Therapy*: ECRI reviewed 1 systematic review and 3 primary studies. The systematic review reported on 28 studies of 1833 patients (1093 MtF [male-to-female]; 801 FtM [female-to-male]) who received endocrine therapy as part of their sex reassignment treatment – 80% of the patients demonstrated significant improvements in gender dysphoria; 78% of the patients demonstrated significant improvements in psychological symptoms; 80% of the patients reported significant improvement in quality of life; and 72% of the patients reported significant improvement in sexual function. The primary studies focused on specific issues and resolutions following hormonal therapy: 1) psychological functioning following testosterone treatment for FtM patients; 2) incidence of breast cancer following androgen deprivation and estrogen treatment for MtF; and 3) mood disorders following hormonal treatment starting by age 32.

• *Sexual Reassignment Surgery*: ECRI evaluated 2 systematic reviews and 4 primary studies. One review included 25 studies of patients having undergone MtF penile skin inversion and the bowel vaginoplasty technique, in which the sexual function and patient satisfaction were considered "overall acceptable." The second review indicated that sexual satisfaction was "high"; however, quality of life was not reported. The primary studies focused on patient satisfaction, postoperative complications, psychosocial and sexual well-being, mortality, morbidity, and criminal rates. One study reported higher overall mortality, increased risk of suicide attempts, psychiatric inpatient care, and higher risk of criminal conviction rates. Other studies reported overall satisfaction with surgical procedures, improved mental health, and better quality of life. Postoperative complications were noted in 2 of the studies.

Later in 2016, ECRI released a summary of hormonal treatment with gonadotropin-releasing hormone (GnRH) analogues that can suppress secretion of luteinizing hormone and follicle-stimulating hormone, being used as a puberty blocker in transgender children and adolescents. (13) The ECRI review indicated the evidence is consistent in showing that GnRH analogues benefit this transgender population by improving symptoms of depression, anxiety, body image, emotional and behavioral problems, and quality of life.

Revisions Following Initial GRS Treatment

Revisions to primary or secondary sexual characteristics should always be interpreted in the context of specific benefit language. The requirement of the presence of a functional impairment for a specific etiology may vary as applied to any physiological condition. It should be noted that the presence of a functional impairment would render treatment medically necessary and thus not subject to contractual definitions of reconstructive or cosmetic.

Reversal Following Regret of GRS Treatment

Misdiagnosed gender dysphoric patients may regret any gender reassignment treatments. Regret following hormonal and surgical treatment was reported at 1.83% in an 8-year case series reported by Judge et al., in 2014, of 218 patients of both transgender sexes. (14) In 2014, Dhejne et al. reported 2.2% (n=15) of the 767 patients over 50 years experienced regrets, but over time, the number of regrets has significantly declined. (15) This study was inclusive of both transgender sexes. Two other studies were reviewed from Krege et al. (16), and Nelson et al. (17), all of which reported 0% reported no regrets following gender reassignment surgery (GRS) treatments.

Seven patients who regretted their decision to undergo MtF sexual reassignment surgery were studied by Djordjevic et al. (18) Following 3 independent psychiatric evaluations for each patient, reversal surgeries were planned: 4 patients completed all steps of reversal, 2 are partially completed and awaiting completion, and 1 patient has declined a portion of the reversal. The reviewers concluded understanding the characteristics of patients regretting GRS will assist future patients opting for these services.

Ongoing and Unpublished Clinical Trials

A search of ClinicalTrials.gov in March 2019 did not identify any ongoing or unpublished trials that would likely influence this policy.

Professional Guidelines and Position Statements

World Professional Association for Transgender Health (WPATH)

WPATH, formerly the Harry Benjamin International Gender Dysphoria Association, is the most widely recognized SOC and have been recognized by national medical and mental health organizations. (1, 5, 6, 10) WPATH states their overall goal to provide clinical guidance for health professionals to assist transsexuals, transgenders, and gender-nonconforming individuals with safe and effective pathways to achieve lasting personal comfort with their gendered selves, in order to maximize their overall health, psychological well-being, and self-fulfillment. (5)

In the 2012 WPATH SOC Seventh Version, clarifies the recommended medically necessary GRS and related services as the following: (6) 9346206469

"In a June 2008 Clarification Statement, WPATH reiterated the procedures which are considered components of sex reassignment by the Standards of Care and specifically stated that these services are considered medically necessary when clinically indicated. WPATH underscores the clinical significance of the full range of reconstructive interventions including non-genital procedures (e.g., breast augmentation, mastectomy and chest reconstruction, facial feminization surgeries, and facial hair removal).

To ensure treatment effectiveness, WPATH emphasizes that individuals must have access to the procedures which match their clinical needs. Individuals may have a clinical need for specific procedures, although not every individual will require surgery or every possible intervention. Coverage must extend to include the variations which may exist for a given surgery type, and permit a multiple stage surgical process, to ensure clinical appropriateness for the individual." (6, 10)

In November 2015, the International Journal of Transgenderism published recommendations for speech-language therapy for individuals seeking the development of voice and communication that reflects their unique sense of gender. (19) The authors acknowledge the WPATH SOC recognition of speech-language congruency of inner and outer self. Davies et al. expand the speech-language recommendations to include the clinical care by professionals that require trans-specific voice-and-communication assessments, voice feminization protocols-and-voice feminizing surgeries, and voice masculinization protocols. (19)

American Psychiatric Association (APA)

In 2012, the APA Task Force published a report on the treatment of gender identity disorder. (20) The APA stated the following:

"There are some level B studies examining satisfaction/regret following sex reassignment (longitudinal follow-up after an intervention, without a control group); however, many of these studies obtained data retrospectively and without a control group (APA level G). Overall, the evidence suggests that sex reassignment is associated with an improved sense of well-being in the majority of cases, and also indicates correlates of satisfaction and regret. No studies have directly compared various levels of mental health screening prior to hormonal and surgical treatments on outcome variables; however, existing studies suggest that comprehensive mental health screening may be successful in identifying those individuals most likely to experience regrets."

American Academy of Pediatrics (AAP)

In 2018, the AAP released a policy statement, with recommendations focused on children and youth that identify as transgender rather than the larger LGBTQ (lesbian, gay, bisexual, transgender, queer) population. (7) The AAP stated that any discrimination based on

gender identity or expression, real or perceived, is damaging to the socio-emotional health of children, families, and society. In particular, the AAP recommends the following, which includes the psychosocial, healthcare

insurer, medical/mental health provider, community, family, auxiliary service, educational, workforce, legal, and federal government aspects of caring for youth seeking gender reassignment services: (7) 9546396469

1. "That youth who identify as TGD [transgender and gender diverse] have access to comprehensive, gender-affirming, and developmentally appropriate health care that is provided in a safe and inclusive clinical space";

2. "That family-based therapy and support be available to recognize and respond to the emotional and mental health needs of parents, caregivers, and siblings of youth who identify as TGD";

3. "That electronic health records, billing systems, patient-centered notification systems, and clinical research be designed to respect the asserted gender identity of each patient while maintaining confidentiality and avoiding duplicate charts";

4. "That insurance plans offer coverage for health care that is specific to the needs of youth who identify as TGD, including coverage for medical, psychological, and, when indicated, surgical gender-affirming interventions";

5. "That provider education, including medical school, residency, and continuing education, integrate core competencies on the emotional and physical health needs and best practices for the care of youth who identify as TGD and their families";

6. "That pediatricians have a role in advocating for, educating, and developing liaison relationships with school districts and other community organizations to promote acceptance and inclusion of all children without fear of harassment, exclusion, or bullying because of gender expression";

7. "That pediatricians have a role in advocating for policies and laws that protect youth who identify as TGD from discrimination and violence";

8. "That the health care workforce protects diversity by offering equal employment opportunities and workplace protections, regardless of gender identity or expression"; and

9. "That the medical field and federal government prioritize research that is dedicated to improving the quality of evidence-based care for youth who identify as TGD".

Centers for Medicare and Medicaid Services (CMS)

In the CMS Proposed Decision Memo for Gender Dysphoria and Gender Reassignment Surgery released in June 2016, CMS stated the following: (21)

"While we are not issuing a NCD [National Coverage Determination], CMS encourages robust clinical studies that will fill the evidence gaps and help inform the answer to the question posed in this proposed decision memorandum. Based on the gaps identified in the clinical evidence, these studies should focus on which patients are most likely to achieve improved health outcomes with gender reassignment surgery, which types of surgery are most appropriate, and what types of physician criteria and care setting(s) are needed to ensure that patients achieve improved health outcomes."

Section Summary: Gender Reassignment Surgery

BlueCross BlueShield of Illinois

If you, or someone you are helping, have questions, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 855-710-6984.

العربية Arabic	إن كان لديك أو لدى شخص تساعده أسئلة، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون أية تكلفة. للتحدث مع مترجم فوري، اتصل على الرقم 855-710-6984.
繁體中文 Chinese	如果您，或您正在協助的對象，對此有疑問，您有權利免費以您的母語獲得幫助和訊息。洽詢一位翻譯員，請撥電話 並碼 855-710-6984。
Français French	Si vous, ou quelqu'un que vous êtes en train d'aider, avez des questions, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 855-710-6984.
Deutsch German	Falls Sie oder jemand, dem Sie helfen, Fragen haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 855-710-6984 an.
Ελληνικά Greek	Εάν εσείς ή κάποιος που βοηθάτε έχετε ερωτήσεις, έχετε το δικαίωμα να λάβετε βοήθεια και πληροφορίες στη γλώσσα σας χωρίς χρέωση. Για να μιλήσετε σε έναν διερμηνέα, καλέστε 855-710-6984.
ગુજરાતી Gujarati	જો તમને અથવા તમે મદદ કરી રહ્યા હોય એવી કોઈ બીજી વ્યક્તિને એસ.બી.એમ. કાચકામ બાબતે પ્રશ્નો હોય, તો તમને વિના ખર્ચે તમારી ભાષામાં મદદ અને માહિતી મેળવવાનો હક છે. દુભાષિયા સાથે વાત કરવા માટે આ નંબર 855-710-6984 પર કૉલ કરો.
हिंदी Hindi	यदि आपके, या आप जिसकी सहायता कर रहे हैं उसके, प्रश्न हैं, तो आपको अपनी भाषा में निःशुल्क सहायता और जानकारी प्राप्त करने का अधिकार है। किसी अनुवादक से बात करने के लिए 855-710-6984 पर कॉल करें।
Italiano Italian	Se tu o qualcuno che stai aiutando avete domande, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare il numero 855-710-6984.
한국어 Korean	만약 귀하 또는 귀하가 돕는 사람이 질문이 있다면 귀하는 무료로 그러한 도움과 정보를 귀하의 언어로 받을 수 있는 권리가 있습니다. 통역사가 필요하시면 855-710-6984 로 전화하십시오.
Diné Navajo	T'áá ni, éí doodago ła'da bíká'anánilwo'ígíí, na'ídilkidgo, ts'ídá bee ní ahóóti'i' t'áá níík'e níká a'doolwol dóó bina'idilkidígíí bee nił b odoonih. Ata'dahalne'igíí bich'į' hodiilnih kwe'é 855-710-6984.
Polski Polish	Jeśli Ty lub osoba, której pomagasz, macie jakiekolwiek pytania, macie prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer 855-710-6984.
Русский Russian	Если у вас или человека, которому вы помогаете, возникли вопросы, у вас есть право на бесплатную помощь и информацию, предоставленную на вашем языке. Чтобы связаться с переводчиком, позвоните по телефону 855-710-6984.
Español Spanish	Si usted o alguien a quien usted está ayudando tiene preguntas, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 855-710-6984.
Tagalog Tagalog	Kung ikaw, o ang isang taong iyong tinutulungan ay may mga tanong, may karapatan kang makakuha ng tulong at impormasyon sa iyong wika nang walang bayad. Upang makipag-usap sa isang tagasalin-wika, tumawag sa 855-710-6984.
اردو Urdu	اگر آپ کو یا کسی ایسے فرد کو جس کی آپ مدد کر رہے ہیں، کوئی سوال درپیش ہے تو آپ کو اپنی زبان میں مفت مدد اور معلومات حاصل کرنے کا حق ہے۔ مترجم سے بات کرنے کے لیے، 855-710-6984 پر کال کریں۔
Tiếng Việt Vietnamese	Nếu quý vị, hoặc người mà quý vị giúp đỡ, có câu hỏi, thì quý vị có quyền được giúp đỡ và nhận thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, gọi 855-710-6984.

bcbsil.com

Revision 11/21/2016

C.P. v. Blue Cross Blue Shield of Illinois
USDC (W.D. Wash.), No. 3:20-cv-06145-RJB

CONFIDENTIAL EXHIBIT

Filed Under Seal
Pursuant to Protective Order (Dkt. No. 25)

Exhibit O

BlueCross BlueShield of Illinois

ADMINISTRATIVE SERVICES AGREEMENT

The Effective Date of this Agreement is January 1, 2014.

For Employer Group Number(s): As shown on the Account Structure

IN WITNESS WHEREOF, the parties hereto have executed this Agreement as of the date and year specified below.

BLUE CROSS AND BLUE SHIELD OF ILLINOIS, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company

By: _____

Title: Vice President, Underwriting - IL

Date: 8/27/2015

CATHOLIC HEALTH INITIATIVES

ACCOUNT #008591

By: _____

Title: Vice Pres., Employee Benefits

Date: 8/24/15

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This Agreement made as of the Effective Date specified on page one (1) of this Agreement, by and between **Blue Cross and Blue Shield of Illinois, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company** (hereinafter referred to as the "Claim Administrator"), and Catholic Health Initiatives, as Plan Administrator (as defined below) ("Client"), for the Employer Group Number(s) set forth on page one (1) of this Agreement, WITNESSETH AS FOLLOWS:

RECITALS

WHEREAS, the Client is an employer and is also related to various other affiliates, subsidiaries, divisions or similar which have employees (collectively the "Employer"); and

WHEREAS, the Client on behalf of the Group Health Plan has executed an ASO Benefit Program Application ("ASO BPA") and the Claim Administrator has accepted such ASO BPA attached hereto as Exhibit 4, with such ASO BPA and this Agreement collectively referred to hereinafter as the "Agreement", unless specified otherwise; and

WHEREAS, the Client has established and adopted an employee welfare benefit plan ("Plan") as defined below and as described in its plan document, which shall be provided by the Client to the Claim Administrator along with such other Plan documents; and

WHEREAS, the Client on behalf of the Group Health Plan desires to retain the Claim Administrator to provide certain administrative services with respect to the Plan; and

WHEREAS, it is desirable to set forth more fully the obligations, duties, rights and liabilities of the Claim Administrator and the Client (on behalf of itself and the Employers), as representative of the Group Health Plan, with respect to the Plan;

NOW, THEREFORE, in consideration of these premises and the mutual promises and agreements hereinafter set forth, the parties hereby agree as follows:

SECTION 1: APPOINTMENT

The Client hereby retains and appoints the Claim Administrator to provide services as hereinafter described in connection with the administration of the Plan.

SECTION 2: AGREEMENT DEFINITIONS

2.1 "Administrative Charge" means the monthly service charge that is required by the Claim Administrator for the administrative services performed under this Agreement. The Administrative Charge(s) is indicated in the Fee Schedule specifications of the most current Exhibit 4 - ASO BPA of this Agreement.

2.2 "Alternative Compensation Arrangement Payments" means additional payments made to Network Providers for Covered Services for which no formal Claim form may be submitted, including, but not limited to, capitation payments, performance based reimbursement payments, care coordination payments, and other alternative funding arrangements as set forth in Claim Administrator's arrangement with the Network Provider.

2.3 "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 Covered Persons 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 fi[redacted] Redacted of such estimate, to reflect related costs. (See provisions regarding "CLAIM ADMINISTRATOR'S SEPARATE FINANCIAL ARRANGEMENTS WITH PROVIDERS" in Exhibit 2 of this Agreement.) 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 the Covered Person's benefits under the Plan are secondary to Medicare and/or coverage under any other group program.

2.4 **"Certificate of Creditable Coverage"** means a document which is generated for Covered Persons terminating coverage under the Plan. The certificate is provided to Covered Persons as evidence for credit of health coverage held under the Plan during the term of this Agreement.

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

2.6 **"Claim Charge"** means the amount which appears on a Claim as the Provider's regular charge for service rendered to a patient, without further adjustment or reduction and irrespective of any separate financial arrangement between the Claim Administrator and the particular Provider. (See provisions regarding "CLAIM ADMINISTRATOR'S SEPARATE FINANCIAL ARRANGEMENTS WITH PROVIDERS" in Exhibit 2 of this Agreement.)

2.7 **"Claim Payment"** means the benefit calculated by the Claim Administrator, plus any related Surcharges, upon submission of a Claim, in accordance with the benefits specified in the Plan. All Claim Payments shall be calculated on the basis of the Provider's Eligible Charge, Maximum Allowance and/or Dental Maximum Allowance, in accordance with the benefit coverage(s) elected on the most current Exhibit 4 - ASO BPA, for Covered Services rendered to the Covered Person, irrespective of any separate financial arrangement between the Claim Administrator and the particular Provider. (See provisions regarding "CLAIM ADMINISTRATOR'S SEPARATE FINANCIAL ARRANGEMENTS WITH PROVIDERS" in Exhibit 2 of this Agreement.) Claim payment also includes Client's pro rata share of Alternative Compensation Arrangement Payments.

2.7A **"Client"** means Catholic Health Initiatives, or its successor or assigns permitted pursuant to Section 14.4.

2.8 **"Coinsurance"** means a percentage of an eligible expense that a Covered Person is required to pay toward a Covered Service.

2.9 **"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. A Covered Person must be homebound (that is, unable to leave home without assistance and requiring supportive devices or special transportation) and must require Skilled Nursing Service on an intermittent basis under the direction of a Physician, 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. A Coordinated Home Care Program includes occupational and speech therapists, Hospital laboratories, and necessary medical supplies. The program does not include and is not intended to provide benefits for Private Duty Nursing Service. It also does not cover services for activities of daily living (personal hygiene, cleaning, cooking, etc.).

2.10 **"Copayment"** means a specified dollar amount that a Covered Person is required to pay toward a Covered Service.

2.11 **"Covered Employee"** shall (i) have the same meaning as defined in the Plan or (ii) such other individuals reported by the Client to Claim Administrator as eligible for and included under the Plan.

2.12 **"Covered Person"** shall (i) have the same meaning as defined in the Plan or (ii) such other individuals reported by the Client to Claim Administrator as eligible for and included under the Plan.

2.13 **"Covered Service"** means a service or supply specified in the Plan for which benefits will be provided.

2.14 **"Custodial Care Service"** means any service primarily for personal comfort or convenience that provides general maintenance, preventive, and/or protective care without any clinical likelihood of improvement of a Covered Person's condition. Custodial Care Services also means those services which do not require the technical skills, professional training and clinical assessment ability of medical and/or nursing personnel in order to be safely and effectively performed. These services can be safely provided by trained or capable

non-professional personnel, are to assist with routine medical needs (e.g. simple care and dressings, administration of routine medications, etc.) and are to assist with activities of daily living (e.g. bathing, eating, dressing, etc.). Custodial Care Service also means providing care on a continuous Inpatient or Outpatient basis without any clinical improvement by the Covered Person.

2.15 "Dental Maximum Allowance" means one of the following amounts in accordance with the type of dental benefits coverage elected, if dental benefits coverage is elected on the most current Exhibit 4 - ASO BPA:

a. For a Provider who has a written agreement with the Claim Administrator or the entity chosen by the Claim Administrator to administer a participating provider option dental benefits program at the time Covered Services for dental benefits are rendered ("Participating Dentist"), the amount such Participating Dentist has agreed to accept as payment in full for a particular Covered Service. All benefit payments for Covered Services rendered by Participating Dentists will be based on the Schedule of Maximum Allowances which these Providers have agreed to accept as payment in full.

b. For a Provider who does not have a written agreement with the Claim Administrator or the entity chosen by the Claim Administrator to administer a participating provider option dental benefits program at the time Covered Services for dental benefits are rendered ("Non-Participating Dentist"), the amount described in i. or ii. below, in accordance with the type of dental benefits coverage elected by the Client:

i. The lesser of the Non-Participating Dentist's Claim Charge or an amount that is equal to the standard contracted fee for Participating Dentists in the same geographic area. In the event such lesser amount does not equate to the Non-Participating Dentist's Claim Charge, a Covered Person will be responsible for the difference between such amount and the Claim Charge, along with any applicable Copayment, Coinsurance and deductible amount(s).

ii. The lesser of the Non-Participating Dentist's Claim Charge or the Claim Administrator's "Dental Usual and Customary Charge" amount which is developed from base Medicare reimbursements and represents approximately 100% of the base Medicare reimbursement rate, excluding any Medicare adjustment(s) which is/are based on information on the Claim.

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 Dental Usual and Customary Charge will be 50% of the Non-Participating Dentist's standard Claim Charge for such Covered Service.

The Claim Administrator will utilize the same Claim processing rules and/or edits that it utilizes in processing all Participating Dentist Claims for processing Claims submitted by Non-Participating Dentists which may also alter the Dental Usual and Customary Charge for a particular Covered Service. In the event the Claim Administrator does not have any Claim edits or rules, the Claim Administrator may utilize the Medicare claim rules or edits that are used by Medicare in processing such Claims. The Dental Usual and Customary 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 Dental Usual and Customary Charge amount does not equate to the Non-Participating Dentist's Claim Charge, a Covered Person 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 145 days after the effective date that such change is implemented by the Centers for Medicaid and Medicare Services, or its successor.

2.16 "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 a Covered Person at the time Covered Services for medical benefits are rendered ("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 a Covered Person at the time Covered Services for medical benefits are rendered ("Non-Participating Provider"), the lesser of:

i. the Non-Participating Provider's Claim Charge; or

ii. the Claim Administrator's non-contracting Eligible Charge. Except as otherwise provided in this definition, the non-contracting Eligible Charge is developed from base Medicare reimbursements and represents approximately Redacted of the base Medicare reimbursement rate and will exclude any Medicare adjustment(s) which is/are based on information on the Claim.

Notwithstanding the preceding sentence, the non-contracting Eligible Charge for Coordinated Home Care Program Covered Services will be Redacted of the Non-Participating Provider's standard Claim Charge for such Covered Services.

The base Medicare reimbursement rate described above will exclude any Medicare adjustment(s) which is/are based on information on the Claim.

When a Medicare reimbursement rate is not available for a Covered Service or is unable to be determined on the information submitted on the Claim, the Eligible Charge for the Non-Participating Provider will be Redacted of the Non-Participating Provider's standard Claim Charge for such Covered Service.

The Claim Administrator will utilize the same Claim processing rules and/or edits that it utilizes in processing Participating Provider Claims for processing Claims submitted by Non-Participating 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 or rules, the Claim Administrator may utilize the Medicare claim rules or edits that are used by Medicare in processing such 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.

Any change to the Medicare reimbursement amount will be implemented by the Claim Administrator within 145 days after the effective date that such change is implemented by the Centers for Medicaid and Medicare Services, or its successor.

2.16A "Employer" means the Client, along with various other affiliates, subsidiaries, divisions or similar which have employees, and which entity is either (i) designated by the Client to the Claim Administrator either for services under this Agreement or (ii) is a participating employer under the Plan with respect to a Covered Employee as determined by the Client.

2.17"ERISA" means the Employee Retirement Income Security Act of 1974, as amended.

2.18"Fee Schedule" means the specifications setting out certain particulars of this Agreement as set forth in Exhibit 4 - ASO BPA of this Agreement including, but not limited to, the Administrative Charge and other service charges; or any such other subsequent set of specifications supplied by the Claim Administrator as set forth in a subsequent ASO BPA as replacement to the initial Exhibit 4 - ASO BPA. The specifications or items of the Fee Schedule shall be applicable to the Fee Schedule Period therein, except that any item of the Fee Schedule may be changed in accordance with Exhibit 2's "COMPENSATION TO CLAIM ADMINISTRATOR" provisions.

2.19"Fee Schedule Period" means the period of time indicated in the Fee Schedule specifications of the most current Exhibit 4 - ASO BPA of this Agreement.

2.20"Group Health Plan" or "Plan" means, the Catholic Health Initiatives ERISA Welfare Benefit Plan a self-insured employee welfare benefit plan as defined by Section 160.103 of the Health Insurance Portability and Accountability Act of 1996 established by the Client, in effect as of the Effective Date, for the benefit of the Covered Employees as determined by the Plan documents; provided, however, that the Client may report to the Claim Administrator as covered under this Agreement other welfare benefit plans, programs or arrangements sponsored by one or more Employers, which in such event such plans, programs or arrangements shall be deemed and treated as a Group Health Plan or Plan covered by this Agreement, effective as of the dates provided by the Client, until removed by the Client from the scope of this Agreement upon notice to the Claim Administrator.

2.21"HIPAA" means the Health Insurance Portability and Accountability Act of 1996.

2.22"Hospital" means a duly licensed institution for the care of the sick which provides service under the care of a physician including the regular provision of bedside nursing by registered nurses. It does not mean health resorts, rest homes, nursing homes, skilled nursing facilities, convalescent homes, custodial homes of the aged or similar institutions.

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

2.24"Maximum Allowance" means in the case of a professional Provider one of the following amounts in accordance with the type of medical benefits coverage elected on the most current Exhibit 4 - ASO BPA:

a. For a professional Provider who has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide care to a Covered Person at the time Covered Services for medical benefits are rendered ("Participating Professional Provider"), the amount such Participating Professional Provider has agreed to accept as payment in full for a particular Covered Service. All benefit payments for Covered Services rendered by a Participating Professional Provider will be based on the Schedule(s) of Maximum Allowances which such Provider has agreed to accept as payment in full.

b. For a professional Provider who does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide care to a Covered Person at the time Covered Services for medical benefits are rendered ("Non-Participating Professional Provider"), the lesser of the Non-Participating Professional Provider's Claim Charge or the Claim Administrator's non-contracting Maximum Allowance amount which is developed from base Medicare reimbursements and represents approximately 100% of the base Medicare reimbursement rate, excluding any Medicare adjustment(s) which is/are based on information on the Claim.

Notwithstanding the preceding sentence, the non-contracting Maximum Allowance for Coordinated Home Care Program Covered Services will be 50% of the Non-Participating Professional Provider's standard Claim Charge for such Covered Services.

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 non-contracting Maximum Allowance will be 50% of the Non-Participating Professional Provider's standard Claim Charge for such Covered Service.

The Claim Administrator will utilize the same Claim processing rules and/or edits 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 or rules, 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, a Covered Person 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 145 days after the effective date that such change is implemented by the Centers for Medicaid and Medicare Services, or its successor.

2.25"Net Claim Payment" means the net benefit payment calculated by the Claim Administrator, upon submission of a Claim, in accordance with the benefits specified in the Plan, plus any related Surcharges. All Net Claim Payments shall be calculated on the basis of the Provider's Eligible Charge for Covered Services rendered to the Covered Person, less the ADP if applicable, irrespective of any separate financial arrangement between the Claim Administrator and the particular Provider. (See provisions regarding "CLAIM ADMINISTRATOR'S SEPARATE FINANCIAL ARRANGEMENTS WITH PROVIDERS" in Exhibit 2 of this Agreement.)

2.26"Network" means identified Providers, including physicians, other professional health care providers, Hospitals, ancillary providers, and other health care facilities, that have entered into agreements with the Claim Administrator (and, in some instances, with other participating Blue Cross and/or Blue Shield Plans) for participation in a participating provider option and/or point–of–service managed care health benefits coverage program(s), if applicable to the Plan under this Agreement.

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

2.28 "Outpatient Prescription Drug Program Eligible Charge" means (a) in the case of a Provider which has a written agreement with the Claim Administrator, a Blue Cross and Blue Shield Plan or the entity chosen by the Claim Administrator to administer its prescription drug program at the time Covered Services are rendered ("Participating Prescription Drug Provider"), such Provider's Claim Charge for Covered Services; and **(b)** in the case of a Provider which does not have a written agreement with the Claim Administrator, a Blue Cross and Blue Shield Plan or the entity chosen by the Claim Administrator to provide prescription drug services to a Covered Person at the time Covered Services are rendered ("Non-Participating Prescription Drug Provider"), the lesser of the following charges for Covered Services:

i. the charge which the particular Non-Participating Prescription Drug Provider usually charges for Covered Services, or

ii. the agreed upon cost between Participating Prescription Drug Providers and the Claim Administrator, a Blue Cross and Blue Shield Plan or the entity chosen by the Claim Administrator to administer its prescription drug program.

2.29 "Physician" means a physician duly licensed to practice medicine in all of its branches.

2.29A "Plan Administrator" means the Client, which is responsible for the operation and administration of the Plan. The Client is deemed to be and is treated as the Plan Administrator.

2.30"Primary Care Physician" means a physician who is a Network Provider at the time Covered Services are rendered under the Claim Administrator's point–of–service managed care health benefits coverage program, if applicable to the Plan under this Agreement, and who is selected by or assigned to a Covered Person to coordinate and arrange for the Covered Person's medical care and who approves and makes medically appropriate referrals for any non–Primary Care Physician services and who provides medical care within the scope of a license permitting him/her to legally practice medicine in the recognized areas of pediatrics, obstetrics and gynecology, internal medicine and family practice.

2.31"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 eight (8) hours or greater per day and does not include nursing care of less than eight (8) hours per day. Private Duty Nursing Service does not include Custodial Care Service.

2.32"Provider" means any Hospital, health care facility, laboratory, person or entity duly licensed to render Covered Services to a Covered Person or any other provider of medical or dental services, products or supplies which are Covered Services.

2.33"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.

2.34"Supplemental Charge" means a charge for costs due and payable to the Claim Administrator by the Client that is separate and apart from the service charges detailed in the Fee Schedule specifications of the most current Exhibit 4 - ASO BPA of this Agreement. A Supplemental Charge may be applied for any customized reports, forms or other materials or for any additional services or supplies not documented in the Fee Schedule specifications of the most current Exhibit 4 - ASO BPA. Such services and/or supplies and any applicable Supplemental Charge(s) are to be agreed upon by the parties in writing prior to the Claim Administrator's performance and/or provision of such.

2.35"Surcharges" means local, state or federal taxes, surcharges or other fees or amounts, including, but not limited to World Access Fees and amounts due in connection with the Affordable Care Act Transitional Reinsurance Programs (or successor or alternate program amounts) (the "Reinsurance Contribution"), paid by the Claim Administrator which are imposed upon or resulting from this Agreement, or are otherwise payable by or through Claim Administrator. Upon request, Client shall furnish to Claim Administrator in a timely manner all information necessary for the calculation or administration of any Surcharges. Surcharges

may or may not be related to a particular claim for benefits. In no event will Claim Administrator be responsible for the Reinsurance Contribution.

2.36 **"Timely"** means the following, unless an alternative standard is specified in this Agreement or is mutually agreed to by the parties in writing:

a. With respect to all payments due the Claim Administrator by the Client under this Agreement, within ten (10) calendar days of notification of the Client by the Claim Administrator; or

b. With respect to all information due the Claim Administrator by the Client concerning Covered Persons, within thirty–one (31) calendar days of a Covered Person's effective date of coverage or change in coverage status under the Plan; or

c. With respect to all Plan information due the Claim Administrator by the Client, upon the effective date of this Agreement and at least ninety (90) calendar days prior to the effective date of change or amendment to the Plan thereafter.

2.37 **"World Access Fee"** means the Surcharge imposed upon the Claim Administrator under the BlueCard® Worldwide program for the administration of an international Claim.

SECTION 3: SERVICES TO BE PROVIDED BY THE CLAIM ADMINISTRATOR

3.1 ***Subcontractors.*** During the continuance of this Agreement, the Claim Administrator will perform such services as set forth in Exhibit 1 of this Agreement, attached hereto and made a part hereof. The Claim Administrator, at its sole discretion, may contract with other entities for performance of any of the services to be performed by the Claim Administrator hereunder; provided, however, the Claim Administrator shall remain fully responsible for integrating and ensuring delivery of all services contracted for it under this Agreement, regardless of which entity delivers the services and liable for performance of any such services to be performed by the Claim Administrator but delegated to other entities.

3.2 ***Subsidiaries.*** Further, any of the services to be performed by the Claim Administrator under this Agreement may be performed by the Claim Administrator, or any of its subsidiaries (including any successor corporation, whether by merger, consolidation, or reorganization), without prior written approval by the Client. Any reference in this Agreement to the Claim Administrator shall include its directors, officers and employees as well as the directors, officers and employees of any of its subsidiaries and the Claim Administrator shall be responsible and liable for all performance or failure to perform by such subsidiaries in connection with this Agreement.

SECTION 4: CERTAIN RESPONSIBILITIES OF THE CLIENT AND THE CLAIM ADMINISTRATOR

4.1 ***Client Responsibility.*** The Client retains full and final authority and responsibility for the Plan and its operation. The Claim Administrator is empowered to act on behalf of the Client in connection with the Plan only as expressly stated in this Agreement or as mutually agreed to in writing by the parties hereto.

4.2 ***Claim Administrator Responsibility.*** The Claim Administrator shall have no responsibility for or liability with respect to the compliance or non–compliance of the Plan with any applicable federal, state and local rules, laws and regulations; and the Client shall have the sole responsibility for and shall bear the entire cost of compliance with all federal, state and local rules, laws and regulations, including, but not limited to, any licensing, filing, reporting, modification requirements and disclosure requirements as may apply to the Plan, and all costs, expenses and fees relating thereto, including but not limited to local, state or federal taxes, penalties, surcharges or other fees or amounts regardless of whether payable directly by Client or by or through Claim Administrator; provided, however, the Claim Administrator shall have the responsibility for and bear the cost of compliance with any federal, state or local laws as may apply to the Claim Administrator in connection with the performance of its obligations under this Agreement.

4.3 ***Litigation.*** Each party shall, to the extent possible, advise the other party of any legal actions against it or the other party which involve the Plan or the obligations of either party under the Plan or this Agreement. The Client shall undertake the defense of such action and be responsible for the costs of defense; provided, however, that the Claim Administrator shall have the option, at its sole discretion, to employ attorneys

selected by it to defend any such action, the costs and expenses of which shall be the responsibility of the Claim Administrator. It is further agreed that each party (provided no conflicts of interest exist) shall fully cooperate with the other party in the defense of any action arising out of matters related to the Plan or this Agreement.

4.4 ***Claim overpayments.*** The Client acknowledges that unintentional administrative errors may occur. When the Claim Administrator becomes aware of a Claim overpayment, the Claim Administrator will make a diligent attempt to recover any such payment. The Claim Administrator, however, will not be required to enter into litigation to obtain a recovery, unless specifically provided for elsewhere in this Agreement, nor will the Claim Administrator be required to reimburse the Plan, except for gross negligence or intentional acts by the Claim Administrator.

4.5 ***Required Plan information.*** The Client shall furnish on a Timely basis to the Claim Administrator certain information concerning the Plan and Covered Persons as may from time to time be required by the Claim Administrator for the performance of its duties including, but not limited to, the following:

a. All documents by which the Plan is established and any amendments or changes to the Plan.

b. All data as may be required by the Claim Administrator regarding Covered Persons who are to be covered under this Agreement.

It is the Client's obligation to Timely notify the Claim Administrator of any change in a Covered Person's status under this Agreement. All such notifications by the Client to the Claim Administrator (including, but not limited to, forms and tapes) must be furnished in a format mutually agreed to by the parties and must include all information reasonably required by the Claim Administrator to effect such changes.

4.6 ***Plan eligibility errors.*** Clerical errors in keeping or reporting data relative to coverage under this Agreement will not invalidate coverage that would otherwise be validly in force or continue coverage which would otherwise validly terminate. Such errors will be corrected by the Claim Administrator subject to the terms and conditions of this Agreement and the Claim Administrator's reasonable administrative practices in the administration of the Plan including, but not limited to, those related to Timely notification of a change in a Covered Person's status. The Client is liable for any benefits paid for a terminated Covered Person until the Client has notified the Claim Administrator of such Covered Person's termination.

4.7 ***Claim information disclosure.*** The Claim Administrator will disclose Claim information in accordance with HIPAA privacy regulations and the Business Associate Agreement entered into by the parties.

4.8 ***Electronic exchange of information.*** In the event the Client and the Claim Administrator exchange various data and information electronically, the Client agrees to transfer on a Timely basis all required data to the Claim Administrator via electronic transmission on the intranet and/or internet or otherwise, in a format mutually agreed to by the parties. Further, the Client is responsible for maintaining any enrollment applications and change forms completed by Covered Persons and to allow the Claim Administrator reasonable access to this information as needed for administrative purposes.

The Client authorizes the Claim Administrator to submit reports, data and other information to the Client in the electronic format mutually agreed to by the parties. In the event the Client is unable or unwilling to transfer data in the electronic format mutually agreed to by the parties, the Claim Administrator is under no obligation to receive or transmit data in any other format unless required by law to do so. In the event garbled or intercepted transmissions occur, the parties agree to redirect the information via another mutually agreeable means.

SECTION 5: THIRD PARTY DATA RELEASE

5.1 ***Types of data.*** In the event the Client directs the Claim Administrator to provide data directly to its third party consultant and/or vendor and the Claim Administrator accepts, the Client acknowledges and agrees, and will cause its third party consultant and/or vendor to acknowledge and agree:

a. The personal and confidential nature of the requested documents, records and other information (for purposes of this Section 5, "Confidential Information").

b. Release of the Confidential Information may also reveal the Claim Administrator's confidential, business proprietary and trade secret information (for purposes of this Section 5, "Proprietary Information").

c. To maintain the confidentiality of the Confidential Information and any Proprietary Information (for purposes of this Section 5, collectively, "Information").

5.2 ***Third party obligations.*** The third party consultant and/or vendor shall:

a. Use the Information only for the purpose of complying with the terms and conditions of its contract with the Client.

b. Maintain the Information at a specific location under its control and take reasonable steps to safeguard the Information and to prevent unauthorized disclosure of the Information to third parties, including those of its employees not directly involved in the performance of duties under its contract with the Client.

c. Advise its employees who receive the Information of the existence and terms of these provisions and of the obligations of confidentiality herein.

d. Use, and require its employees to use, at least the same degree of care to protect the Information as is used with its own proprietary and confidential information.

e. Not duplicate the Information furnished in written, pictorial, magnetic and/or other tangible form except for purposes of this Agreement or as required by law.

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

g. Execute the Claim Administrator's then–current confidentiality agreement.

5.3 ***Client obligations.*** The Client shall:

a. Designate the third party consultant and/or vendor on the appropriate HIPAA documentation.

b. Provide the Claim Administrator with the appropriate authorization and specific written directions with respect to data release or exchange with the third party consultant and/or vendor.

c. Indemnify, defend (at the Claim Administrator's request) and hold harmless the Claim Administrator and its employees, officers, directors and agents against any and all losses, liabilities, damages, penalties and expenses, including attorneys' fees and costs, or other cost or obligation resulting from or arising out of claims, lawsuits, demands, settlements or judgments brought against the Claim Administrator in connection with any claim based upon the Claim Administrator's disclosure to the third party consultant and/or vendor of any information and/or documentation regarding any Covered Person at the direction of the Client or breach by the third party consultant and/or vendor of any obligation described in this Agreement.

SECTION 6: REFERRAL OF CERTAIN CLAIMS/INQUIRIES

As provided in this Agreement, the Claim Administrator will receive eligibility information, review and process Claims, and respond to customer inquiries; however, the Claim Administrator does not have final authority to determine Covered Persons' eligibility or to establish or construe the terms and conditions of the Plan. Therefore, in certain instances, the Claim Administrator may refer certain Claims to the Client for review and final decision. Such referral shall be at the sole discretion of the Claim Administrator.

SECTION 7: CLAIM DISPUTE RESOLUTION

7.1 ***Claim appeals.*** After exhaustion of all remedies offered by the Claim Administrator, a Covered Person may appeal all adverse determinations with the Client. The Claim Administrator will cooperate in providing Claim information pursuant to Section 4 above.

7.2 ***Claim reviews.*** On occasion the Claim Administrator may deny all or part of submitted Claims. The Claim Administrator will provide a full and fair review of any determination of a Claim, any determination of a request for pre–notification, and any other determination made in accordance with the benefits and procedures detailed in the Plan.

SECTION 8: FINAL DETERMINATION OF CLAIMS/INQUIRIES

8.1 ***Client authority and responsibility.*** The Client retains the final authority and responsibility to establish and construe the terms and conditions of the Plan and to determine Covered Persons' eligibility.

8.2 ***Referrals to Client.*** Certain claims and/or inquiries will be referred to the Client for final review and determination in the following instances:

a. When Claims for services do not appear to qualify for payment under the Plan, claims or inquiries where there is a question of eligibility, claims where there is a question as to the amount of payment due, and claims involving litigation or the threat of litigation; and

b. When a Covered Person chooses to appeal adverse determinations with the Client after exhaustion of all remedies offered by the Claim Administrator.

SECTION 9: COOPERATION OF THE PARTIES

The parties shall use their best efforts to cooperate with and assist each other, as applicable, in the performance of their duties under this Agreement.

SECTION 10: HIPAA/CERTIFICATE OF CREDITABLE COVERAGE

10.1 ***HIPAA requirement.*** The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") requires the preparation and distribution of a Certificate of Creditable Coverage to individuals who terminate coverage under the Plan.

10.2 ***Responsible party.*** In accordance with the Client's election indicated on the most current Exhibit 4 - ASO BPA of this Agreement:

a. ***If the Client elects the Claim Administrator to issue certificates,*** the Claim Administrator shall issue a Certificate of Creditable Coverage consistent with the requirements under HIPAA. The Certificate of Creditable Coverage shall be based upon coverage under the Plan during the term of this Agreement and information provided to the Claim Administrator by the Client.

b. ***If the Client does not elect the Claim Administrator to issue certificates,*** the Client acknowledges that the Claim Administrator is not the Group Health Plan issuer offering group coverage under the Group Health Plan nor the plan administrator and, therefore, the Claim Administrator has no obligation to prepare or distribute a Certificate of Creditable Coverage. The Client further acknowledges that the obligation to provide a Certificate of Creditable Coverage is the obligation of the Client.

SECTION 11: INDEMNIFICATION

11.1 ***Claim Administrator indemnifies Client.*** The Claim Administrator hereby agrees to indemnify and hold harmless the Client and its directors, officers, employees, agents, affiliates, and Plan fiduciaries, against any and all loss, liability, damages, penalties and expenses, including attorneys' fees, or other cost or obligation resulting from or arising out of claims, lawsuits, demands, settlements or judgments with respect to the Plan or this Agreement resulting from or arising out of any acts or omissions of the Claim Administrator or its directors, officers or employees which have been adjudged to be (i) negligent, dishonest, fraudulent or criminal or (ii) in material breach of the terms of this Agreement; provided, however, notwithstanding anything herein to the contrary pursuant to Section 12.2 below, the Claim Administrator shall be responsible for the correction of Claim Payment and/or Net Claim Payment errors by the Claim Administrator.

11.2 ***Client indemnifies Claim Administrator.*** The Claim Administrator does not insure or underwrite the liability of the Client under the Plan and has no responsibility for designing the terms of the Plan or the benefits to be provided thereunder. The Client retains the ultimate responsibility for claims under the Plan and all expenses incident to the Plan, except as specifically undertaken in this Agreement by the Claim Administrator. The Client agrees to indemnify and hold harmless the Claim Administrator and its directors, officers and employees against any and all loss, liability, damages, penalties and expenses, including attorneys' fees, or other cost or obligation resulting from or arising out of claims, lawsuits, demands,

settlements or judgments brought against the Claim Administrator in connection with the design or administration of the Plan, unless the liability therefor was the direct consequence of the acts or omissions of the Claim Administrator or its directors, officers or employees and is adjudged to be (i) negligent, dishonest, fraudulent or criminal or (ii) in material breach of the terms of this Agreement; provided, however, notwithstanding anything herein to the contrary pursuant to Section 12.2 below, the Claim Administrator shall be responsible for the correction of Claim Payment and/or Net Claim Payment errors by the Claim Administrator.

11.3 ***Examples of actions brought against Claim Administrator.*** The following list is intended to exemplify types of actions related to design and administration of the Plan(s), but not to allocate indemnification responsibility with respect to such examples, which shall be determined in accordance with Section 11.1 or 11.2, as applicable.

a. Any claim in connection with a claim for benefits under the Plan.

b. Any claim based upon the disclosure of any information regarding a Covered Person by the Claim Administrator to the Client.

c. Any claim in connection with un–Timely and/or inaccurate eligibility data or Claim information data provided by the Client to the Claim Administrator, or any such data provided by the Client in a format not approved by the Claim Administrator.

d. Any claim arising from the Client's use or posting of electronic files on the intranet and/or internet pursuant to Section 17 below.

e. Any claim that may arise from or in connection with the Claim Administrator's suspension of Claim Payments due to the Client's failure to pay when due any amounts owed the Claim Administrator under this Agreement and/or the termination of this Agreement in accordance with Section 13.2 below.

f. Any claim arising from the Client's directive to the Claim Administrator to print Client–assigned unique identification numbers on membership identification cards or to otherwise use such assigned numbers in violation of any applicable federal, state and local rules, laws and regulations.

g. Any claim arising from the Client's directive to the Claim Administrator to include mutually agreed upon Client ERISA Summary Plan Description information in Claim Administrator prepared benefit booklets for distribution to Covered Persons.

h. Any claim arising from Plan documentation and compliance with reporting and disclosure requirements of ERISA applicable to the Plan Document and Summary Plan Description.

i. Any claim that may arise from or in connection with the Claim Administrator's issuance of Certificate(s) of Creditable Coverage, if elected on the most current Exhibit 4 - ASO BPA, based upon un–Timely and/or inaccurate data provided by the Client to the Claim Administrator with respect to individuals whose coverage under this Agreement terminates.

j. Any claim based upon Medicare Secondary Payer ("MSP) laws or regulations including, but not limited to, the untimely and/or inaccurate provision by the Client to the Claim Administrator of Client Acknowledgement Forms ("EAFs") as and when requested by the Claim Administrator.

k. Any claim that may rise from or in connection with the Claim Administrator's issuance of written statements of creditable coverage and/or the filing of electronic reports to the Massachusetts Department of Revenue, if elected on the most current Exhibit 4 - ASO BPA, based upon untimely and/or inaccurate data or certification provided by the Client to the Claim Administrator with respect to Covered Persons under the Agreement subject to the Massachusetts Health Care Reform Act.

SECTION 12: AUDIT AND CORRECTION OF AUDIT ERRORS

12.1 ***Client audits Claim Administrator.*** During the term of this Agreement and within one (1) year after its termination (or such later date as needed for the Plan to comply with ERISA), the Client or an authorized agent of the Client (subject to Claim Administrator's reasonable approval) may, upon at least sixty (60) days prior written notice to the Claim Administrator, conduct reasonable audits of records related to this Agreement to verify that Claim Administrator's administration of the covered health care benefits is performed according to the terms of this Agreement and the benefits specified in the Plan(s). The audit must be free of bias, influence or conflict of interest. Contingency fee based audits are deemed to have an

inherent conflict of interest and will not be supported by Claim Administrator. Audit samples will be limited to no more than three hundred (300) Claims. The Client will be responsible for all costs associated with the audit. Claim Administrator reserves the right to charge Client for any reasonable personnel time in excess of one hundred sixty (160) person-hours required to support audits conducted during the term of this Agreement. Client will reimburse Claim Administrator for all reasonable expenditures necessary to support audits conducted after termination of this Agreement. All such audits shall be subject to the Claim Administrator's current external audit policy and procedures, a copy of which shall be furnished to the Client upon request to the Claim Administrator. No more than one (1) audit shall be conducted during a twelve (12) consecutive-month period, except as required by state or federal government agency or regulation. The audit period will be limited to the most recent twenty-four (24) or for such other period required by any governmental agency or as maybe required for the Client to comply with ERISA or applicable law. A report by the Claim Administrator's independent accountant on the controls over claims adjudication (known as a SOC 1 report) is provided at no cost upon request. The Client and such agent that have access to the information and files maintained by the Claim Administrator will agree not to disclose any proprietary information, and to hold harmless and indemnify the Claim Administrator in writing of any liability from disclosure of such information by executing an Audit Agreement with the Claim Administrator that sets forth the terms and conditions of the audit.

12.2 ***Errors identified.*** The Claim Administrator shall be responsible for the correction of errors identified in during the Audit subject to the terms and conditions of the Agreement.

SECTION 13: TERM AND TERMINATION OF AGREEMENT

13.1 ***Term.*** This Agreement will continue in full force and effect from the effective date and continue from year to year unless terminated as provided herein.

13.2 ***Termination.*** This Agreement may be terminated as follows:

a. By either party at the end of any month after the end of the Fee Schedule Period indicated in the Fee Schedule specifications of the most current Exhibit 4 - ASO BPA upon ninety (90) days prior written notice to the other party.

b. By both parties on any date mutually agreed to in writing.

c. By either party, in the event of fraud, misrepresentation of a material fact or not complying with the terms of this Agreement, upon written notice as provided under Section 22 below.

d. By the Claim Administrator, upon the Client's failure to pay all amounts due under this Agreement including, but not limited to, all amounts pursuant to and in accordance with the specifications of the Fee Schedule of the most current Exhibit 4 - ASO BPA.

e. By either party immediately upon written notice in the event of: the bankruptcy, insolvency or liquidation of the other party.

13.3 ***Notice of termination to Covered Employees.*** If this Agreement is terminated pursuant to this Section 13, the Client agrees to notify all Covered Employees. The parties agree that the Client will give such notice because the Client maintains direct and ongoing communication with, and maintains current addresses for, all such Covered Employees.

SECTION 14: RELATIONSHIP OF PARTIES

14.1 ***Regarding the parties.*** The Claim Administrator is an independent contractor with respect to the Client. Neither party shall be construed, represented or held to be an agent, partner, associate, joint venturer nor employee of the other.

Further, nothing in this Agreement shall create or be construed to create the relationship of employer and employee between the Claim Administrator and the Client; nor shall the Client's agents, officers or employees be considered or construed to be considered employees of the Claim Administrator for any purpose whatsoever.

14.2 ***Regarding non–parties.*** It is understood and agreed that nothing contained in this Agreement shall confer or be construed to confer any benefit on persons who are not parties to this Agreement including, but not limited to, employees of an Employer and their dependents.

14.3 ***Exclusivity.*** The Client agrees not to engage any other party to perform the same services that the Claim Administrator performs hereunder while this Agreement is in effect, unless the Client gives notice of termination pursuant to the terms of this Agreement.

14.4 ***Assignment.*** Except as otherwise permitted by Section 3 of this Agreement, no part of this Agreement, or any rights, duties or obligations described herein, shall be assigned or delegated without the prior express written consent of both parties. Any such attempted assignment shall be null and void. The Claim Administrator's standing contractual arrangements for the acquisition and use of facilities, services, supplies, equipment and personnel shall not constitute an assignment under this Agreement.

SECTION 15: ERISA

15.1 ***In relation to the Plan.*** The Client hereby acknowledges (i) that an employee welfare benefit plan must be established and maintained through a separate plan document which may include the terms hereof or incorporate the terms hereof by reference, and (ii) an employee welfare benefit plan document may provide for the allocation and delegation of responsibilities thereunder. However, notwithstanding anything contained in the Plan or any other employee welfare benefit plan document of the Client, the Client agrees that no allocation or delegation of any fiduciary or non-fiduciary responsibilities under the Plan or any other employee welfare benefit plan of the Client is effective with respect to or accepted by the Claim Administrator.

15.2 ***In relation to the Plan Administrator/Named Fiduciary(ies).*** The Claim Administrator is not the plan administrator of the Client's separate employee welfare benefit plan as defined under ERISA. It is understood and agreed that (i) the Client has a named Plan Administrator and a Named Fiduciary within the meaning of § 414(g) of the Internal Revenue Code of 1986, as amended; (ii) said Plan Administrator serves within the meaning of § 3(16)(A) of ERISA; and (iii) the Claim Administrator is not a fiduciary of the Client, the Plan Administrator or of the Plan.

15.3 ***In Relation to Claim Administrator's Responsibilities.*** The Claim Administrator's responsibilities hereunder are intended to be limited to those of a contract claims administrator rendering advice to and administering claims on behalf of the plan administrator of the Client's Plan. As such, the Claim Administrator is intended to be a fiduciary with respect to the Client's ERISA employee welfare benefit plan. The Client represents that its ERISA employee welfare benefit plan contains the plan procedure described above regarding the designation of responsibilities under a plan and, accordingly, the Claim Administrator may, pursuant to Sections 402(c)(2) and 405(c)(1)(B) of ERISA, render advice with respect to claims and administer claims on behalf of the plan administrator of the Client's ERISA welfare benefit plan. The Claim Administrator has no other authority or responsibility with respect to Client's ERISA employee welfare benefit plan.

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SECTION 16: PROPRIETARY MATERIALS

16.1 ***Types of materials as may be used by the parties.*** The parties acknowledge that each party has developed operating manuals, certain symbols, trademarks, service marks, designs, data, processes, plans, procedures and information, all of which are proprietary information ("Business Proprietary Information"). Neither party shall use or disclose to any third party Business Proprietary Information without prior written consent of the other party. Neither party shall use the name, symbols, copyrights, trademarks or service marks ("Proprietary Marks") of the other party or the other party's respective clients in advertising or promotional materials without prior written consent of the other party; provided, however, that the Claim Administrator may include the Client in its list of clients.

16.2 ***Claim Administrator/Association ownership.*** The Client acknowledges that the Claim Administrator's Proprietary Marks and Business Proprietary Information are the sole property of the Blue Cross and Blue Shield Association or of the Claim Administrator and agrees not to contest the Blue Cross and Blue Shield

Association's or the Claim Administrator's ownership or the license granted to the Claim Administrator for use of such Proprietary Marks.

16.3 ***Infringement.*** The Claim Administrator agrees not to infringe upon, dilute or harm the Client's rights in its Proprietary Marks. The Client agrees not to infringe upon, dilute or harm the Blue Cross and Blue Shield Association's ownership rights or the Claim Administrator's rights as a licensee in its Proprietary Marks.

16.4 ***Disclosures in Account Contracts.*** The Client on behalf of itself and its Covered Persons hereby expressly acknowledges its understanding this Agreement constitutes a contract solely between the Client and the Claim Administrator, which is an independent corporation operating under a license from the Blue Cross and Blue Cross Association, an association of independent Blue Cross and Blue Shield Plans, (the "Association") permitting the Claim Administrator to use the Blue Cross and Blue Shield Service Mark ,and that the Claim Administrator is not contracting as the agent of the Association. The Client on behalf of itself and its Covered Persons further acknowledges and agrees that it has not entered into this Agreement based upon representations by any person other than the Claim Administrator and that no person, entity, or organization other than the Claim Administrator shall be held accountable or liable to the Client for any of the Claim Administrator's obligations to the Client created under this Agreement. This subsection shall not create any additional obligations whatsoever on the part of the Claim Administrator other than those obligations created under other provisions of this Agreement.

16.5 ***Administrative Services Only, Network Only.*** The Claim Administrator must disclose that it does not underwrite or assume any financial risk with respect to Claims liability; and disclose the nature of the services and/or network access the Claim Administrator is providing. Such disclosures must be made to the Client, the Covered Persons, and Providers and must include, at a minimum, disclosure on identification cards, benefit booklets, Client contracts and Explanation of Benefits documentation.

SECTION 17: ELECTRONIC DOCUMENTS

17.1 ***Client's consent/intended use.*** The Client consents to receive via an electronic file or access to an electronic file any document the Client requests from the Claim Administrator describing the benefits under, or the administration of, the Plan.

17.2 ***Client acknowledgement/responsibilities.*** The Client further acknowledges and agrees that it is responsible for providing employees access, via the intranet, internet, or otherwise, to the most current version of any electronic file provided to the Client by the Claim Administrator at the Client's request. In addition, in all instances, the electronic file of the most current document issued to the Client by the Claim Administrator for use by the Client is the legal document used to administer the Plan and will prevail in the event of any conflict between such electronic file and any other electronic or paper file. The Client is solely responsible for any and all claims for loss, liability or damages, arising either directly or indirectly from the use or posting of the electronic file on the intranet and/or internet.

SECTION 18: RECORDS

All Claim records, excluding any and all of the Claim Administrator's Business Proprietary Information, in the possession of the Claim Administrator are and shall remain the property of the Client upon termination of this Agreement. The Claim Administrator shall return such property upon request in a form as agreed upon by the parties at the cost of preparing such property for transmittal to be borne by the Client. All such Claim records shall be retained by the Claim Administrator until the Claim Administrator receives a request from the Client for transmittal or for a period of ten (10) years from the date of a Claim's adjudication, whichever occurs first.

SECTION 19: APPLICABLE LAW

This Agreement shall be governed by, and shall be construed in accordance with, the laws of the state of Illinois without regard to any state choice-of-law statutes, and any applicable federal law. All disputes arising out of this Agreement will be resolved in Illinois.

SECTION 20: ENTIRE AGREEMENT

20.1 ***Definition.*** This Agreement, including all Exhibits and Addenda, represents the entire agreement and understandings of the parties hereto and all prior agreements, understandings, representations and warranties, whether written or oral, in regard to the subject matter hereof, including any proposal document submitted by the Claim Administrator to the Client pursuant to this Agreement, are and have been merged herein to the extent applicable. In the event of a conflict, the provisions of this Agreement and the Exhibits and Addenda of this Agreement shall prevail.

20.2 ***Components.*** The Exhibits and Addenda of this Agreement as of the Agreement's effective date are:

- **a.** Exhibit 1 - Claim Administrator Services
- **b.** Exhibit 2 - Fee Schedule, Financial Responsibilities & Required Disclosures
- **c.** Exhibit 3 - Recovery Litigation Authorization
- **d.** Exhibit 4 - ASO Benefit Program Application ("ASO BPA")
- **e.** Exhibit 5 - COBRA Health Benefits Continuation Coverage ("COBRA")

20.3 ***Amending.*** This Agreement may be amended or altered in any of its provisions, including the addition or deletion of any Exhibits and/or Addenda as provided herein, by the parties hereto and any such change shall become effective when reduced to writing and signed by an authorized representative of the parties or at such time as said amendment may provide.

SECTION 21: LIMITATIONS

No civil action shall be brought to recover under this Agreement after the expiration of three (3) years from the date the cause of action accrued, except to the extent that a later date is permitted under Section 413 of ERISA.

SECTION 22: NOTICE AND SATISFACTION

Unless specifically stated otherwise in this Agreement, the Client and the Claim Administrator agree to give one another written notice (pursuant to Section 26 Notices below) of any complaint or concern the other party may have about the performance of obligations under this Agreement and to allow the notified party thirty (30) days in which to make necessary adjustments or corrections to satisfy the complaint or concern prior to taking any further action with regard to such.

SECTION 23: LIMITATION OF LIABILITY

Liability for any errors or omissions by the Claim Administrator (or its officers, directors, employees, agents or independent contractors) in the administration of this Agreement, or in the performance of any duty or responsibility contemplated by this Agreement, shall be limited to the maximum benefits which should have been paid under this Agreement had the errors or omissions not occurred (including the Claim Administrator's share of any arbitration expenses incurred), unless any such errors or omissions are adjudged to be the result of intentional misconduct, gross negligence or intentional breach of a duty under this Agreement by the Claim Administrator.

SECTION 24: DISPUTE RESOLUTION/ARBITRATION

24.1 ***Initial negotiation.*** Any dispute arising out of or relating to this Agreement shall be resolved in accordance with the procedures specified in this Section 24, which shall be the sole and exclusive procedures for the resolution of any such disputes. All negotiations pursuant to this Section 24 are confidential and shall be treated as compromise and settlement negotiations for purposes of applicable rules of evidence.

24.2 ***Deferring to arbitration/selecting an arbitrator.*** In the event the parties fail to agree with respect to any matter covered herein, the question in dispute shall be submitted for arbitration in Illinois. The arbitrator shall be selected as follows:

a. Upon declaration by one of the parties hereto that a deadlock exists, the parties shall select an arbitrator;

b. If no appointment is made within thirty (30) days after the deadlock is declared and the amount in contest is in excess of $200, the American Arbitration Association shall recommend an arbitrator; or

c. If no appointment is made within thirty (30) days after the deadlock is declared and the amount in question is $200 or less, the Claim Administrator shall select an independent third party to be the arbitrator.

24.3 ***Expectations.*** The arbitrator will submit a decision within thirty (30) days after appointment or as soon as reasonably feasible and such decision shall be binding on the parties hereto. Arbitration expenses will be shared by the parties. All other expenses (legal, incidental, etc.) shall be borne by the losing party or, if both parties prevail, be apportioned by the arbitrator to each party. Arbitration proceedings will be governed by the Rules of the American Arbitration Association then in effect.

SECTION 25: OBLIGATION TO CONTINUE PERFORMANCE

Except as provided otherwise in this Agreement, each party is required to continue to perform its obligations under this Agreement pending final resolution of any dispute arising out of or relating to this Agreement.

SECTION 26: NOTICES

26.1 ***How to notify.*** All notices given under this Agreement must be in writing and shall be deemed to have been given for all purposes when personally delivered and received or when deposited in the United States mail, first–class postage prepaid, and addressed to the parties' respective contact names at their respective addresses or when transmitted by facsimile via their respective facsimile numbers as indicated on the most current Exhibit 4 - ASO BPA of this Agreement.

26.2 ***Change of address.*** Each party may change such notice mailing and/or transmission information upon Timely prior written notification to the other party.

SECTION 27: SEVERABILITY

Should any provision(s) contained in this Agreement be held to be invalid, illegal, or otherwise unenforceable, the remaining provisions of the Agreement shall be construed in their entirety as if separate and apart from the invalid, illegal or unenforceable provision(s) unless such construction were to materially change the terms and conditions of this Agreement.

SECTION 28: ENFORCEMENT

Any delay or inconsistency in the enforcement of any part of this Agreement shall not constitute a waiver of any rights with respect to the enforcement of this Agreement at any future date nor shall it limit any remedies which may be sought in any action to enforce any provision of this Agreement.

SECTION 29: FORCE MAJEURE

Neither party shall be liable for any failure to Timely perform its obligations under this Agreement if prevented from doing so by a cause or causes beyond its commercially reasonable control including, but not limited to, acts of God or nature, fires, floods, storms, earthquakes, riots, strikes, wars or restraints of government.

SECTION 30: INDUSTRY IMPROVEMENT, RESEARCH AND SAFETY

Notwithstanding any other provision of this Agreement, the Claim Administrator may use and or disclose a limited data set or de-identified data for purposes of providing the services under this Agreement and for other purposes required or permitted by applicable law (the "Permitted Purposes" as defined herein). For purposes of this

paragraph, "Permitted Purposes" means the studies, analyses or other activities that are designed to promote quality health care outcomes, manage health care and administrative costs, and enhance business and plan performance, including but not limited to, utilization studies, cost analyses, benchmarking, modeling, outcomes studies, medical protocol development, normative studies, quality assurance, credentialing, network management, network development, fraud and abuse monitoring or investigation, administrative or process improvement, cost comparison studies, or reports for actuarial analyses. For purposes of this paragraph, a "limited data set" has the meaning set forth in HIPAA and "de-identified" means both member de-identification (as defined by HIPAA) and Client de-identification (unless the work is being done in connection with the Client's Plan). Solely for the Permitted Purposes, the Claim Administrator may release, or authorize the release of, a limited data set or de-identified data to a third party data aggregation service or data warehouse and its customers. Such data warehouse and data aggregation service providers may charge their customers a fee for such services. Nothing in the paragraph is intended to expand or limit the terms and conditions of the Business Associate Agreement with respect to the permitted use or disclosure of PHI. The foregoing notwithstanding, the Blue Cross and Blue Shield Association and its support vendors are permitted to have internal access to the Claim Administrator-assigned Employer Group and Identification numbers.

SECTION 31: CLAIM ADMINISTRATOR USE OF THIRD PARTY RECOVERY VENDOR

Recoveries from healthcare providers can arise in several ways, including, but not limited to, anti-fraud and abuse recoveries, healthcare provider/hospital audits, credit balance audits, data mining, utilization review refunds, and unsolicited refunds. The Claim Administrator may engage a third party to assist in identification or collection of recovery amounts related to Claim Payments and Net Claim Payments made under the Agreement. In such event, the recovered amounts will be applied according to the Claim Administrator's refund recovery policies, which generally require correction on a Claim-by Claim basis. Third parties' reasonable audit fees associated with such audits and the Claim Administrator's reasonable fee for its related administrative expenses to support such third party audits will be paid by the Client.

SECTION 32: NOTICE OF ANNUAL MEETING

The Client is hereby notified that it is a Member of Health Care Service Corporation (HCSC), a Mutual Legal Reserve Company, and is entitled to vote either in person, by its designated representative, or by proxy at all meetings of Members of said Company. The annual meeting is held at its principal office at 300 East Randolph Street, Chicago, Illinois each year on the last Tuesday in October at 12:30 P.M.

For purposes of this Agreement, the term "Member" means the group, trust, association or other entity with which this Agreement has been entered. It does not include Covered Employees or Covered Persons under the Plan.

SECTION 33: ETHICS

33.1 The Claim Administrator hereby represents that it is not at this time excluded from participation in any health care program, as defined at 42 U.S.C. § 1320a-7b(f), including Medicare and Medicaid. The Claim Administrator hereby agrees to notify Client within ten (10) business days of any, actual exclusion from any federally funded health care program, including Medicare and Medicaid. In the event that the Claim Administrator or any of its subcontractors is excluded from participation in any federal health care program during the term of this Agreement, or if at any time after the effective date of this Agreement it is determined that the Claim Administrator is in breach of this Section, the Client may terminate this Agreement immediately upon notice to the Claim Administrator as provided in Section 13.

33.2 Client and all of its facilities are Equal Employment Opportunity and Affirmative Action employers. The parties hereby incorporate by reference the provisions of Executive Order 11246, as amended, and 41 C.F.R. § 60-1.4(a); the Rehabilitation Act of 1973, as amended, and 41 C.F.R. § 60-741.5(a); the Vietnam Era Veterans' Readjustment Assistance Act, as amended, and 29 C.F.R. § 60-250.5(a); and Executive Order 13496 and 29 C.F.R. Part 471, Appendix A to Subpart A. The Claim Administrator represents and warrants that unless exempted under the terms of these applicable laws, it will comply with the foregoing Executive Orders, statutes, rules and regulations and all amendments thereto.

33.3 The Claim Administrator recognizes that it is essential to the core values of Client that all persons and entities contracting with Client at all times conduct themselves in compliance with the highest standards of business ethics and integrity and applicable legal requirements as reflected in the Catholic Health Initiatives Standards of Conduct, as may from time to time be amended by the Client. As of the date of the Agreement, the Catholic Health Initiatives Standards of Conduct are set forth in Our Values & Ethics at Work Reference Guide ("Reference Guide"), which is available at the following website: http://www.catholichealthinitiatives.org/corporate-responsibility.

33.4 The Claim Administrator acknowledges that it has electronically accessed, obtained or otherwise received a copy of the Reverence Guide and has read and understands the same, and hereby agrees that, so long as the Agreement remains in effect, the Claim Administrator shall act in a manner consistent with, and shall at all times abide by, such Standards of Conduct, to the extent the same are applicable to the Claim Administrator in the performance of the Agreement.

EXHIBIT 1
CLAIM ADMINISTRATOR SERVICES

- **CLAIMS ADJUDICATION**

  Examination of Claims and determination of payment levels, including data entry of Claims by Claims departments, maintenance of Claims experience files, use of medical consultants, review of utilization and reasonable and customary charges; and, if dental benefits coverage is elected on the most current Exhibit 4 - ASO BPA, use of dental consultants and review of Usual and Customary Fees; and Coordination of Benefits (COB).

- **EXPLANATION OF BENEFITS (EOB)**

  Preparation of EOBs.

- **CLAIMS/MEMBERSHIP INQUIRIES**

  Handling of inquiries — written, phone or in–person – related to membership, benefits, and Claim Payment, Net Claim Payment or Claim denial (including providing notice in writing through the EOB when a Claim for benefits has been denied which notice shall set forth the reasons for the denial and the right to a full and fair review of the denial under the terms of the Plan and shall otherwise satisfy applicable regulatory requirements, including, but not limited to, those of ERISA and related law applicable to the Plan, governing the notice of a denied Claim and external review of appeals consistent with applicable law. Notwithstanding any provision of this Agreement to the contrary, Client has the right to reasonably direct the Claim Administrator with respect to any claims under the Plan in any particular case or circumstance, subject to Claim Administrator's right to disregard such Client's direction consistent with applicable law), such prudent customer service shall be provided by Claim Administrator at a level consistent with industry standards and reasonable due diligence.

- **ALTERNATIVE PROVIDER COMPENSATION ARRANGEMENTS**

  Client agrees to participate in other performance based reimbursement and alternative provider compensation arrangements as applicable based on Covered Person criteria established by Claim Administrator. Client agrees that certain benefits will be covered at Redacted when a Covered Person meets these criteria and participates in a medical home program, and will make any necessary benefit plan changes.

- **ENROLLMENT SERVICE**

  Upon Client request, assist Client, in accordance with Claim Administrator's standard procedures, in initial enrollment activities, including education of Covered Persons about benefits, the enrollment process, selection of health care providers and how to file a Claim for benefits; issue Claim submission instructions on behalf of Client to health care providers who render services to Covered Persons.

- **CLIENT SERVICES AND MATERIALS**

  Provision of those items as elected by Client from listing below:

  a. ***Enrollment Materials.*** Implementation materials to be provided by Claim Administrator's Marketing Administration Division during the enrollment process; any custom designed materials may be subject to Supplemental Charge.

  b. ***Standard Identification Cards.*** Provision of identification cards appropriate to health benefit Plan coverage(s) selected.

  c. ***Standard Provider Directories.*** Access to Network Provider directories and periodic updates to such, if applicable to the health benefit Plan coverage(s) under the Agreement.

  d. ***Customer Service.*** Access to toll–free customer service telephone number.

  e. ***Medical Pre–notification Helpline.*** For those services described in the Plan and provided in writing to Claim Administrator that require pre–notification, advance Claim Administrator review of medical

necessity of such services covered under the Plan; access to toll–free medical pre–notification helpline for Covered Persons and their health care providers to call for assistance.

- **MEMBERSHIP VALIDATION**

  Verification of membership by wire, listing, electronic on–line query or other method prior to or during adjudication.

- **MEMBERSHIP FILE UPDATES**

  Maintenance of membership status files, processing of inter–plan transfers and processing of contract changes; and, if elected in the Fee Schedule specifications of the most current Exhibit 4 - ASO BPA, processing of contract conversions, subject to conversion fee set forth therein.

- **OTHER MEMBERSHIP SERVICES**

  Contact Client and/or Covered Employees regarding adding, changing or renewing coverage.

- **STANDARD REPORTS**

  Make available Claim data, Claim Settlement statements (as outlined in Exhibit 2, Section 6) and periodic reports in Claim Administrator's standard format(s) in accordance with Claim Administrator's standard reporting policy at no additional charge. Any additional reports required by Client must be mutually agreed upon by the parties in writing prior to their development and may be subject to a Supplemental Charge.

- **STOP LOSS COORDINATION**

  Coordinate all necessary reporting, tracking, notification and other similar financial and/or administrative services pursuant to settlements under stop loss policy(ies) purchased from Claim Administrator in conjunction with the Agreement. For stop loss coverage purchased from entity(ies) other than Claim Administrator, such coordination is limited to this Exhibit's STANDARD REPORTS to be made available to Client subject to the Agreement's disclosure requirements.

- **REPORTING SERVICES**

  Preparation and filing of annual Internal Revenue Service (IRS) 1099 forms for the reporting of payments to health care providers who render services to Covered Persons and who are reimbursed by the Plan for those services.

- **ACTUARIAL AND STATISTICAL**

  Determination of claims projections and pricing of administrative services and stop–loss coverage.

- **FINANCIAL SERVICES**

  Financial functions such as cash receipts, cash disbursements, payroll and general ledger processing, general accounting, preparation of financial statements, billing, group settlement and wire transfers.

- **FRAUD DETECTION AND PREVENTION**

  Identify and investigate suspected fraudulent activity by Providers and/or Covered Persons and inform Client of findings and proof of fraud; address any related recovery litigation as set forth in Exhibit 3 of the Agreement.

- **BLUE ACCESS® FOR EMPLOYERS**

  Provides Client on–line access to conduct a variety of secure membership, enrollment, reporting, administrative and billing transactions faster, more accurately and in real–time.

- **BLUE ACCESS® FOR MEMBERS**

  An on–line resource for personalized information about a Covered Person's health care coverage, including, but not limited to, Claims status, email notification when a Claim has been finalized, access to health and wellness information, verification of dependents covered on their plan and health risk assessment and such other services as become available.

- **PROVIDER NETWORK(S)**

  If applicable to the health benefit Plan coverage(s) under the Agreement, establish, arrange and maintain a Network(s) through contractual arrangements with Providers including, if also applicable, Primary Care Physicians within the designated service area.

- **CERTIFICATE OF CREDITABLE COVERAGE (*If elected on the most current Exhibit 4 - ASO BPA*)**

  Issuance of Certificates of Creditable Coverage.

- **BLUE CARE CONNECTION® PROGRAM (*If elected on the most current Exhibit 4 - ASO BPA)***

  A program that may include utilization management, case management, condition management, lifestyle management, predictive modeling, Well on Target, 24/7 nurseline and access to a personal health manager or such other features as determined by the Client.

- **DISEASE/CARE MANAGEMENT PROGRAM(S)**

  Any disease and/or care management program(s) as elected on the most current Exhibit 4 - ASO BPA.

- **MASSACHUSETTS STATEMENTS OF CREDITABLE COVERAGE AND ELECTRONIC REPORTING**

  (If elected on the most current Exhibit 4 - ASO BPA)

  At the written direction of Client, issuance of written statements of creditable coverage and related electronic reporting to the Massachusetts Department of Revenue with respect to Covered Persons under the Agreement subject to the Massachusetts Health Care Reform Act.

- **MSP INFORMATION REPORTING**

  Pursuant to Exhibit 2, Section 17 entitled "MEDICARE SECONDARY PAYER ("MSP") INFORMATION REPORTING", reporting preparation and filing as required of Claim Administrator as Responsible Reporting Entity ("RRE") for the Plan as that term is defined in Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007.

- **UNCASHED CHECKS**

  Regarding outstanding checks that are or become "stale" (over 365 days old), issue notification letters to payees and upon completion of notification process, reissue such checks to payees based upon payee response, if any. When check reissuance is not possible and unless stated otherwise in the Agreement, escheat such checks to state of payee's last known residence on behalf of Client or escheat amounts pursuant to such checks to Client, as elected by the Client, less any amount(s) owed by payee to Claim Administrator, in accordance with Claim Administrator's established procedures and/or the applicable state's unclaimed property law.

- **ADDITIONAL SERVICES NOT SPECIFIED**

  Claim Administrator may provide additional services not specified in the Agreement; such services will be mutually agreed upon between the parties in writing prior to their performance and may be subject to Supplemental Charge.

EXHIBIT 2
FEE SCHEDULE, FINANCIAL RESPONSIBILITIES & REQUIRED DISCLOSURES

SECTION 1: FEE SCHEDULE

Service charges and other service specifications applicable to the Agreement are set forth in the Fee Schedule section of the most current Exhibit 4 - ASO BPA of the Agreement. They are to apply for the period(s) of time indicated therein and shall continue in full force and effect until the earlier of: i) the end of the Fee Schedule Period noted on such ASO BPA; ii) the date a Fee Schedule is amended or replaced in its entirety by the execution of a subsequent ASO BPA; and iii) the date the Agreement is terminated.

Inter-Plan Program Fees:

i. **BlueCard® Program/Network access fees* (as applicable):** Additional information is available upon request; included in the Medical Administrative Charge(s) noted in the ASO BPA and in any Termination Administrative Charge(s) noted in the ASO BPA calculated on the basis of such Medical Administrative Charge(s);

ii. **Negotiated National Account Arrangement/Custom fees (as applicable):** Additional information is available upon request; included in the Medical Administrative Charge(s) noted in the ASO BPA and in any Termination Administrative Charge(s) noted in the ASO BPA calculated on the basis of such Medical Administrative Charge(s);

iii. *For* **Non-Participating Healthcare Providers Outside Claim Administrator's Service Area/processing fees (as applicable):** Additional information is available upon request; included in the Medical Administrative Charge(s) noted in the ASO BPA and in any Termination Administrative Charge(s) noted in the ASO BPA calculated on the basis of such Medical Administrative Charge(s).

**Such fees may not exceed the lesser of the applicable annual percentage of the discount (dependent upon group size) permitted under the BlueCard Program or* Redacted *per Claim.*

SECTION 2: EXHIBIT DEFINITIONS

Other definitions applicable to this Exhibit are contained in Section 2 AGREEMENT DEFINITIONS of the Agreement.

2.1 "Employer Payment" means the amount owed or payable to the Claim Administrator by the Client for a given Employer Payment Period in accordance with Section 5 of this Exhibit which is the sum of Net Claim Payments made plus applicable service charges incurred during that Employer Payment Period.

2.2 "Employer Payment Method" means the method elected in the Fee Schedule specifications of the most current Exhibit 4 - ASO BPA of the Agreement by which Employer Payments will be made.

2.3 "Employer Payment Period" means the time period indicated in the Fee Schedule specifications of the most current Exhibit 4 - ASO BPA of the Agreement.

2.4 "Medicare Secondary Payer ("MSP")" means those provisions of the Social Security Act set forth in 42 U.S.C. §1395 y (b), and the implementing regulations set forth in 42 C.F.R. Part 411, as amended, which regulate the manner in which certain employers may offer group health care coverage to Medicare–eligible employees, their spouses and, in some cases, dependent children. (See Section 17 of this Exhibit titled "MEDICARE SECONDARY PAYER ("MSP") INFORMATION REPORTING.")

2.5 "Run–Off Claim" means a Claim incurred prior to the termination of the Agreement that is submitted for payment during the Run–Off Period.

2.6 "Run–Off Period" means the time period immediately following termination of the Agreement, indicated in the Fee Schedule specifications of the most current Exhibit 4 - ASO BPA of the Agreement, during which the Claim Administrator will accept Run-Off Claims submitted for payment.

2.7 **"Termination Administrative Charge"** means the consideration indicated in the Fee Schedule specifications of the most current Exhibit 4 - ASO BPA of the Agreement that is required by the Claim Administrator upon termination of the Agreement, including any services that may be performed by the Claim Administrator during the Run-Off Period indicated on such ASO BPA.

SECTION 3: COMPENSATION TO CLAIM ADMINISTRATOR

3.1 ***Intent of service charges.*** The Client will pay service charges to the Claim Administrator, in accordance with the Fee Schedule specifications of the most current Exhibit 4 - ASO BPA of the Agreement, as compensation for the processing of Claims and administrative and other services provided to the Client.

3.2 ***Determining service charges.*** The service charges, which are guaranteed for the Fee Schedule Period indicated in the Fee Schedule specifications of the most current Exhibit 4 - ASO BPA of the Agreement, have been determined in accordance with the Claim Administrator's current regulatory status and the Client's existing benefit program.

3.3 ***Changing service charges.*** Such service charges shall be subject to change by the Claim Administrator as follows:

- **a.** At the end of the Fee Schedule Period indicated in the Fee Schedule specifications of the most current Exhibit 4 - ASO BPA of the Agreement, provided that sixty (60) days prior written notice is given by the Claim Administrator;
- **b.** On the effective date of any changes or benefit variances in the Plan, its administration, or the level of benefit valuation which would increase the Claim Administrator's cost of administration;
- **c.** On any date changes imposed by governmental entities increase expenses incurred by the Claim Administrator, provided that such increases shall be limited to an amount sufficient to recover such increase in expenses;
- **d.** On any date that the actual number of Covered Employees (in total, by product or by benefit plan), the Single/Family mix, or the Medicare/Non-Medicare mix varies +/- ten percent (10%) from Claim Administrator's projections;
- **e.** The information upon which Claim Administrator's projections were based (benefit levels, census/demographics, commissions, etc.) becomes outdated or inaccurate; or
- **f.** On any date an affiliate, subsidiary, or other business entity is added or dropped by the Client.

3.4 ***Service charges upon termination.*** In the event the Agreement is terminated in accordance with the "TERM AND TERMINATION" provisions of the Agreement, the Client will Timely pay the Claim Administrator the Termination Administrative Charge indicated in the Fee Schedule specifications of the most current Exhibit 4 - ASO BPA of the Agreement.

3.5 ***Additional service charges.*** In addition to the amounts due and payable each month in accordance with the Fee Schedule specifications of the most current Exhibit 4 - ASO BPA of the Agreement, the Claim Administrator may charge the Client for:

- **a.** Any applicable reasonable Supplemental Charge(s);
- **b.** Reasonable fees for the reproduction or return of Claim records requested by the Client, a governmental agency or pursuant to a court order; and/or
- **c.** Any other reasonable fees that may be assessed by third parties for services rendered to the Client and/or any other fees for services mutually agreed upon by the parties in writing.

3.6 ***Effect of Plan enrollment.*** Administrative Charges will be paid based upon information the Claim Administrator receives regarding current Plan enrollment as of the first day of each month. Appropriate adjustments will be made for enrollment variances or corrections.

3.7 ***Timely payment.*** Performance of all duties and obligations of the Claim Administrator under the Agreement are contingent upon the Timely payment of any amount owed the Claim Administrator by the Client.

SECTION 4: CLAIM PAYMENTS

4.1 ***Claim Administrator's payment.*** Upon receipt of a Claim, the Claim Administrator will make a Claim Payment consistent with the Plan and applicable law provided that all payments due the Claim Administrator under the terms of the Agreement are paid when due.

4.2 ***Client's liability.*** Any reasonable determination by the Claim Administrator in adjudicating a Claim under the Agreement that a Covered Person is entitled to a Net Claim Payment is conclusive evidence of the liability of the Client to the Claim Administrator for such Net Claim Payment pursuant to Section 6 below titled "CLAIM SETTLEMENTS."

4.3 ***Covered Person's certain liability.*** Under certain circumstances, if the Claim Administrator pays the healthcare Provider amounts that are the responsibility of the Covered Person under this Agreement, the Claim Administrator may collect such amounts from the Covered Person.

4.4 ***Cessation of Claim Payments.*** If the Client has failed to pay when due any amount owed the Claim Administrator, the Claim Administrator shall be under no obligation to make any further Claim Payments until such default is cured.

SECTION 5: EMPLOYER PAYMENT

5.1 ***Intent.*** In consideration of the Claim Administrator's obligations as set forth in the Agreement and at the end of each Employer Payment Period, the Client shall pay to the Claim Administrator or shall provide access for the Claim Administrator to obtain, the Employer Payment amount due for that Employer Payment Period.

5.2 ***Confirmation or notification of amount due and payment due date.*** The Client shall confirm with the Claim Administrator or the Claim Administrator shall notify the Client's Financial Division, of the Employer Payment for each Employer Payment Period and when such payment is due. Confirmation or notification shall be in accordance with the Employer Payment Method elected in the Fee Schedule specifications of the most current Exhibit 4 - ASO BPA of the Agreement and the following:

- **a.** ***If the Employer Payment Method is by check,*** the Claim Administrator shall issue the Client a settlement statement which will include the Claim Administrator's mailing address for check remittance and the date payment is due.
- **b.** ***If the Employer Payment Method is other than check,*** the Client shall confirm on-line the amount due by accessing the Claim Administrator's "Blue Access for Employers" (as provided in Exhibit 1 of the Agreement); or the Claim Administrator shall advise the Client by email or facsimile (at an email address or facsimile number to be furnished by the Client prior to the effective date of the Agreement) or by such other method mutually agreed to by the parties, of the amount due. The Employer Payment must be made or obtained within forty-eight (48) hours of confirmation by the Client or the Client's notification by the Claim Administrator. If any day on which an Employer Payment is due is a holiday, such payment will be made or obtained on the next business day.

5.3 ***Federal Regulation of Client.*** Beginning in 2014 (or such other date required by law), Client will be responsible for contributing to the funding of the Transitional Reinsurance Programs established by the Affordable Care Act. In no event will Claim Administrator be responsible for the reinsurance contribution. If required by applicable law, Client will promptly forward to Claim Administrator all such contributions (or successor or alternate program amounts) and all information necessary for the calculation or administration of such contributions (or successor or alternate program amounts).

Late payments are subject to the penalties outlined in Section 7.3 of this Exhibit.

SECTION 6: CLAIM SETTLEMENTS

6.1 ***Determining what Client owes.*** A Claim Settlement shall be determined for each Claim Settlement Period indicated in the Fee Schedule specifications of the most current Exhibit 4 - ASO BPA of the Agreement. The Claim Settlement shall reflect the sum of the following:

- **a.** All Net Claim Payments calculated on the basis of Claim Payments paid by the Claim Administrator in the particular Claim Settlement Period.

b. All Net Claim Payments calculated on the basis of Claim Payments paid by the Claim Administrator in prior Claim Settlement Periods that have not been included in a prior Claim Settlement.

c. The Administrative Charges and Credits and other applicable service charges as indicated in the Fee Schedule specifications of the most current Exhibit 4 - ASO BPA of the Agreement and any applicable Supplemental Charge(s).

The sum of a., b., and c. above shall be referred to as the Claim Settlement Total.

6.2 ***Client underpayment.*** If, within the Claim Settlement Period, the Claim Settlement Total exceeds the Employer Payments, the Client will pay the difference to the Claim Administrator. The Claim Settlement will be determined within sixty (60) days from the last day of the Claim Settlement Period. The Claim Administrator will notify the Client in writing of the results of the Claim Settlement. Any sums due the Claim Administrator will be paid Timely by the Client.

6.3 ***Client overpayment.*** If, within the Claim Settlement Period, the Employer Payments exceed the Claim Settlement Total, the Claim Administrator may, at its option, pay such difference to the Client, apply the difference against amounts then owed the Claim Administrator by the Client or authorize a reduction equal to such difference from the next Claim Settlement Total due the Claim Administrator from the Client.

SECTION 7: LATE PAYMENTS AND REMEDIES

7.1 ***When Client fails to Pay.*** If the Client fails to pay when due any amount required to be paid to the Claim Administrator under the Agreement, and such default is not cured within ten (10) days of written notice to the Client, the Claim Administrator may, at its option:

a. Suspend Claim Payments; or

b. Terminate the Agreement as of the effective date specified in such notice.

7.2 ***When Claim Administrator fails to timely notify.*** Pursuant to Section 28 "ENFORCEMENT" of the Agreement, the Claim Administrator's failure to provide the Client with timely notice of any amount due hereunder shall not be considered a waiver of payment of any amount which may otherwise be due hereunder from the Client.

7.3 ***Late charge.*** If the Client fails to make any payment required by the Agreement on a Timely basis, the Claim Administrator, at its option, may assess a daily charge for the late remittance from the due date of any amount(s) payable to the Claim Administrator by the Client. This daily charge shall be an amount equal to the amount resulting from multiplying the amount due times the lesser of:

a. The rate of Redacted per day which equates to an amount of Redacted) per annum; or

b. The maximum rate permitted by state law

7.4 ***Insolvency.*** In addition, if the Client becomes insolvent, however evidenced, or is in default of its obligation to make any Employer Payment as provided hereunder, or if any other default hereunder has occurred and is continuing, then any indebtedness of the Claim Administrator to the Client (including any and all contractual obligations of the Claim Administrator to the Client) may be offset and/or recouped and applied toward the payment of the Client's obligations hereunder, whether or not such obligations, or any part thereof, shall then be due the Client.

SECTION 8: FINANCIAL OBLIGATIONS UPON AGREEMENT TERMINATION

8.1 ***Run-off Claims.*** The Client hereby acknowledges that on the date of termination of the Agreement in accordance with the provisions of either Section 7 of this Exhibit or Section 13 of the Agreement, there may be an undetermined but substantial number of Claims for services rendered or furnished prior to that date which have not been submitted to the Claim Administrator for reimbursement and also an undetermined but substantial number of Claims submitted for reimbursement which have not been paid by the Claim Administrator ("Run-Off Claims"). The Client shall be responsible for the reimbursement of all Run-Off Claims, whether or not such Claims have been submitted, or whether or not Net Claim Payments calculated on the basis of Claim Payments for such Claims have been made by the Claim Administrator, as of the date of termination, including, but not limited to, Claim Payments and/or Net Claim Payments made in accordance with MSP laws, and for the payment of the Termination Administrative Charge and any other

applicable service charges indicated in the Fee Schedule specifications of the most current Exhibit 4 - ASO BPA of the Agreement and any applicable Supplemental Charge(s) pursuant to the processing of such Claims after the Agreement's termination date. Further, if a Covered Person is an Inpatient at the time his or her coverage under the Plan terminates, the Plan shall provide benefits for Covered Services which are provided by and regularly charged for by a Hospital or other facility Provider until the Covered Person is discharged or until the end of the Covered Person's benefit period, whichever occurs first ("Extended Benefits"). The Client shall be liable to the Claim Administrator for all Claim Payments, Net Claim Payments and the applicable service charges for such Extended Benefits.

8.2 ***Corresponding Employer Payments.*** In consideration of the Claim Administrator's continuing to make Claim Payments in accordance with Section 4 of this Exhibit for Run–Off Claims, the Client shall continue to make Employer Payments for all such Claims paid by the Claim Administrator up to the Final Settlement outlined below.

8.3 ***Final Settlement.*** A Final Settlement shall be made within sixty (60) days after the last day of the Run–Off Period. This Final Settlement shall compare the Employer Payments against the Claim Settlement Totals for all Run–Off Claims paid up to the date of the Final Settlement. The difference shall be paid or applied as set forth in Section 6 of this Exhibit. However, if the Employer Payments exceed the Claim Settlement Totals for all Run–Off Claims paid up to the Final Settlement, the Claim Administrator shall pay such difference to the Client after applying the difference against amounts, if any, then owed to the Claim Administrator by the Client.

8.4 ***Uncashed checks.*** As of the date of termination of the Agreement, any outstanding checks that are or become "stale" (over 365 days old) will be escheated by the Claim Administrator, on the Client's behalf, less any amount(s) owed by such checks' payees to the Claim Administrator, in accordance with the applicable state's unclaimed property law.

SECTION 9: REQUIRED DISCLOSURE PROVISIONS

The Client represents that it acknowledges and has communicated the provisions stated in each of the following sections of this Exhibit 2 to its Covered Persons.

SECTION 10: PAYMENT OF CLAIMS AND ASSIGNMENT OF BENEFITS

10.1 ***Claim payment assignment.*** All payments by the Claim Administrator for the benefit of any Covered Person may be made directly to any Provider furnishing Covered Services for which such payment is due, and the Claim Administrator is authorized by such Covered Person to make such payments directly to such Providers. However, the Claim Administrator reserves the right in its sole discretion to pay any benefits that are payable under the terms of the Plan directly to the Covered Person or Provider furnishing Covered Services. All benefits payable to the Covered Person which remain unpaid at the time of the death of the Covered Person will be paid to the estate of the Covered Person.

10.2 ***Claim dispute.*** Once Covered Services are rendered by a Provider, the Covered Person has no right to request the Claim Administrator not to pay the Claim submitted by such Provider and no such request by a Covered Person or his agent will be given effect. Furthermore, the Claim Administrator will have no liability to the Covered Person or any other person because of its rejection of such request.

10.3 ***Plan coverage assignment.*** Neither the Plan nor a Covered Person's claims for payment of benefits under the Plan are assignable in whole or in part to any person or entity at any time. Coverage under the Plan is expressly non–assignable or non–transferable and will be forfeited if a Covered Person attempts to assign or transfer coverage or aids or attempts to aid any other person in fraudulently obtaining coverage under the Plan. However, if the Claim Administrator makes payment because of a person's wrongful use of the identification card of a Covered Person, such payment will be considered a proper payment and the Claim Administrator will have no obligation to pursue recovery of such payment.

SECTION 11: COVERED PERSON/PROVIDER RELATIONSHIP

11.1 ***Choosing a Provider.*** The choice of a Provider is solely the choice of the Covered Person and the Claim Administrator will not interfere with the Covered Person's relationship with any Provider.

11.2 ***Claim Administrator's role.*** It is expressly understood that the Claim Administrator does not itself undertake to furnish Hospital, medical or dental service, but solely to make payment to a Provider for the Covered Services received by Covered Persons. 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 a Covered Person. Professional services which can only be legally performed by a Provider are not provided by the Claim Administrator. Any contractual relationship between a Provider and the Claim Administrator shall not be construed to mean that the Claim Administrator is providing professional service.

11.3 ***If point–of–service coverage applies.*** If coverage under a Network point–of–service managed care health benefits program is applicable to the Plan under the Agreement, the following apply:

a. ***Physician Selection.***

A Covered Person shall be entitled to select a Primary Care Physician through the Plan to act as the Covered Person's principal care giver and to provide or arrange for the provision of medical care.

b. ***Changing Physician Selection.***

Both the Covered Person and the Primary Care Physician may request a change from one Primary Care Physician to another by notifying the Claim Administrator of the desire to change; provided, however, such a request by a Primary Care Physician shall not be based upon the type, amount or cost of services required by the Covered Person or the physical condition of the Covered Person except where reasonably necessary to provide optimal medical care.

11.4 ***Intent of terminology.*** The use of an adjective such as Approved, Administrator, Participating, In–Network or Network 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 Approved, Administrator, Participating, In–Network, Network or any similar modifier or the use of a term such as Non–Approved, Non–Administrator, Non–Participating, Out–of–Network or Non–Network should not be construed as carrying any statement or inference, negative or positive, as to the skill or quality of such Provider.

11.5 ***Provider's role.*** Each Provider provides Covered Services only to Covered Persons and does not deal with or provide any services to the Client (other than as an individual Covered Person) or the Plan.

SECTION 12: LIMITED BENEFITS FOR NON–NETWORK PROVIDERS

Regarding any comprehensive major medical coverage with access to Network Providers elected on the most current Exhibit 4 - ASO BPA of the Agreement. The Client acknowledges that when Covered Persons elect to utilize the services of a non–Network professional Provider for a Covered Service in non–emergency situations, benefit payments to such non–Network professional Provider are not based upon the amount billed. The basis of the 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 under the Plan. Non–Network Providers may bill the Plan's Covered Person for any amount up to the billed charge after the Claim Administrator has paid the Plan's portion of the bill. Network Providers have agreed to accept discounted payments for services with no additional billing to the Covered Person other than Coinsurance and deductible amounts. A Covered Person may obtain further information about the Network status of professional Providers and information on out–of–pocket expenses by calling the toll–free number on their identification card.

SECTION 13: CLAIM ADMINISTRATOR'S SEPARATE FINANCIAL ARRANGEMENTS WITH PROVIDERS

13.1 All amounts payable to the Claim Administrator by the Client for Claim Payments provided by the Claim Administrator and applicable service charges pursuant to the terms of the Agreement and all required deductible and Coinsurance amounts under the Agreement shall be calculated on the basis of the Provider's Eligible Charge or Provider's Claim Charge less the ADP, unless otherwise directed in writing by the Client, for Covered Services rendered to a Covered Person, irrespective of any separate financial arrangement between any Administrator Provider or the Client and the Claim Administrator.

13.2 The Client acknowledges that the Claim Administrator has contracts with certain Providers ("Administrator Providers") for the provision of, and payment for, health care services to all persons entitled to health care benefits under individual certificates, agreements and contracts to which the Claim Administrator is a party, including the Covered Persons under the Agreement, and that pursuant to the Claim Administrator's contracts with Administrator Providers, under certain circumstances described therein, the Claim Administrator may receive substantial payments from Administrator Providers with respect to services rendered to all such persons for which the Claim Administrator was obligated to pay Administrator Providers, or the Claim Administrator may pay Administrator Providers less than their Claim Charges for services, by discounts or otherwise, or may receive from Administrator Providers other allowances under the Claim Administrator's contracts with them. The Client acknowledges that in negotiating the service charges set forth in the Agreement, it has taken into consideration that the Claim Administrator may receive such payments, discounts and/or other allowances during the term of the Agreement and that the service charges specified in the Agreement reflect the amount of additional consideration expected to be received by the Claim Administrator in the form of such payments, discounts or allowances. Neither the Client nor Covered Persons hereunder are entitled to receive any portion of any such payments, discounts and/or other allowances in excess of the ADP as part of any Claim Settlement or otherwise except as such items may be indirectly or directly reflected in the service charges specified in the Agreement.

13.3 The Claim Administrator's compensation for its services under the Agreement shall include the difference between the Net Claim Payments reimbursed to the Claim Administrator by the Client under the Agreement and the net amounts paid to Providers by the Claim Administrator after giving effect to the Claim Administrator's Separate Financial Arrangements with Providers.

Section 14: CLAIM ADMINISTRATOR'S SEPARATE FINANCIAL ARRANGEMENTS WITH PRESCRIPTION DRUG PROVIDERS

14.1 All amounts payable to the Claim Administrator by the Client for Claim Payments provided by the Claim Administrator and applicable service charges pursuant to the terms of the Agreement and all required Copayment, deductible and Coinsurance amounts under the Agreement shall be calculated on the basis of the Outpatient Prescription Drug Program Eligible Charge or the agreed upon cost between the Participating Prescription Drug Provider as defined below, and the Claim Administrator, whichever is less.

14.2 The Claim Administrator hereby informs the Client and all Covered Persons that it has contracts, either directly or indirectly, with prescription drug Providers ("Participating Prescription Drug Providers") for the provision of, and payment for, prescription drug services to all persons entitled to prescription drug benefits under individual certificates, group health insurance policies and contracts to which the Claim Administrator is a party, including the Covered Persons under the Agreement, and that pursuant to the Claim Administrator's contracts with Participating Prescription Drug Providers, under certain circumstances described therein, the Claim Administrator may receive discounts for prescription drugs dispensed to Covered Persons under the Agreement. Actual network savings achieved by the Client will vary. Some rates are currently based on Average Wholesale Price ("AWP"), which is determined by a third party and is subject to change.

14.3 The Client understands that the Claim Administrator may receive such discounts during the term of the Agreement. Neither the Client nor Covered Persons hereunder are entitled to receive any portion of any such discounts except as such items may be indirectly or directly reflected in the service charges specified in the Agreement. The drug fees/discounts that Claim Administrator has negotiated with Prime Therapeutics

LLC ("Prime") through the Pharmacy Benefit Management (PBM) Agreement, will be passed-through to the Client for both retail and mail/specialty drugs. Except for mail/specialty drugs, the PBM Agreement requires that the fees/discounts that Prime has negotiated with pharmacies (or other suppliers) are passed-through to Claim Administrator (and ultimately to the Client as described above). For the mail pharmacy and specialty pharmacy program owned by Prime, Prime retains the difference between its acquisition cost and the negotiated prices as its fee for the various administrative services provided as part of the mail pharmacy and/or specialty pharmacy program. Claim Administrator pays a fee to Prime for pharmacy benefit services, which is reflected in the administrative fee charged by Claim Administrator to the Client. A portion of Prime's PBM fees are tied to certain performance standards, including, but not limited to, claims processing, customer service response, and mail-order processing. The allowable amount reimbursed for prescriptions obtained at out-of-network pharmacies is determined by the Client's benefit design, but is usually based on 75% of the cost of the prescription if it were obtained at an in-network pharmacy.

14.4 "Weighted paid claim" refers to the methodology of counting claims for purposes of determining the Claim Administrator's fee payment to Prime. Each retail (including claims dispensed through PBM's specialty pharmacy program) paid claim equals one weighted paid claim; each extended supply or mail order (including Mail Service) paid claim equals three weighted paid claims. However, Claim Administrator pays Prime a Program Management Fee ("PMF") on a per paid claim basis. "Funding Levers" means a mechanism through which Claim Administrator funds the fees (net fee, ancillary fees and special project fees) owed to PBM. Funding Levers always include manufacturer administrative fees, mail order utilization, participating pharmacy transaction fees, and, if elected by Claim Administrator, may include rebates and retail spread. Claim Administrator's net fee owed to Prime for core services will be offset by the Funding Levers. Claim Administrator pays Prime the net fee for core services, ancillary fees and special project fees, offset by all applicable Funding Levers as agreed upon under the terms of its agreement with Prime. The net fee is calculated based on a fixed dollar amount per Weighted Paid Claim.

14.5 The amounts received by Prime from Claim Administrator, pharmacies, manufacturers or other third parties may be revised from time to time. Some of the amounts received by Prime may be charged each time a claim is processed (or, in some instances, requested to be processed) through Prime and/or each time a prescription is filled, and include, but are not limited to, administrative fees charged by Prime to Claim Administrator (as described above), administrative fees charged by Prime to pharmacies, and administrative fees charged by Prime to pharmaceutical manufacturers. Currently, none of these fees will be passed on to the Employer as expenses, or accrue to the benefit of the Employer, unless otherwise specifically set forth in the Agreement. Additional information about these types of fees or the amount of these fees is available upon request. The maximum that Prime will receive from any pharmaceutical manufacturer for certain administrative fees will be 3% of the total sales for all rebatable products of such manufacturer dispensed during any given calendar year to members of Claim Administrator and other Blue Plan operating divisions.

Section 15: CLAIM ADMINISTRATOR'S SEPARATE FINANCIAL ARRANGEMENTS WITH PHARMACY BENEFIT MANAGERS

15.1 The Claim Administrator hereby informs the Client and all Covered Persons that it owns a significant portion of the equity of Prime and that the Claim Administrator has entered into one or more agreements with Prime or other entities (collectively referred to as "Pharmacy Benefit Managers"), for the provision of, and payment for, prescription drug benefits to all persons entitled to prescription drug benefits under individual certificates, group health insurance policies and contracts to which the Claim Administrator is a party, including the Covered Persons under the Agreement. Pharmacy Benefit Managers have agreements with pharmaceutical manufacturers to receive rebates for using their products. In addition, Prime's mail order pharmacy and other PBM services operate through the same entity, Prime Therapeutics LLC.

15.2 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 manufacturers to cover the administrative costs of processing late payments). Expected Rebate amounts, are calculated based on the Client-specific demographics and projected rebates, interest earnings and utilization. Based upon previous experience with such rebates, the Claim Administrator has estimated that any drug rebate for the Client would be based on an average dollar amount per prescription ("Expected Rebate"). One–hundred percent (100%) of the Expected Rebate is shared with employers based

upon the benefit design and the retail and mail order usage rate. The Expected Rebate passed back to the Client is determined by multiplying the sum of the estimated dollars times the expected number of annual prescriptions dispensed, then divided by the expected number of Covered Employees, then divided by twelve (12) months. The Expected Rebate amount is reflected as a prescription drug rebate credit per Covered Employee per month. Although no true-up is done at the end of the Client's contract period, the re-calculation of the Expected Rebate for the renewal period takes into account the prior period's actual demographics, utilization, rebates and interest earnings. The rebate credits do not continue if the Client terminates.

15.3 The Client understands that the Claim Administrator may receive such rebates during the term of the Agreement. Neither the Client nor Covered Persons hereunder are entitled to receive any portion of any such rebates except as such items may be indirectly or directly reflected in the service charges specified in the Agreement.

SECTION 16: INTER-PLAN ARRANGEMENTS

16.1 ***Out-of-Area Services***

Claim Administrator has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as "Inter-Plan Programs." Whenever Covered Persons access healthcare services outside the geographic area Claim Administrator serves, the Claim for those services may be processed through one of these Inter-Plan Programs and presented to Claim Administrator for payment in accordance with the rules of the Inter-Plan Programs policies then in effect. The Inter-Plan Programs available to Covered Persons under this Agreement are described generally below. Claim Administrator's services under this Agreement are governed by and subject to the Inter-Plan Programs policies in effect during the term of this Agreement.

Typically, Covered Persons, when accessing care outside the geographic area Claim Administrator serves, obtain care from healthcare providers that have a contractual agreement (i.e., are "participating healthcare providers") with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Blue"). In some instances, Covered Persons may obtain care from non-participating healthcare providers. Claim Administrator's payment practices in both instances are described below.

16.2 ***BlueCard® Program***

Under the BlueCard® Program, when Covered Persons access Covered Services within the geographic area served by a Host Blue, Claim Administrator will remain responsible to Client for fulfilling Claim Administrator's contractual obligations. However, in accordance with applicable Inter-Plan Programs policies then in effect, the Host Blue will be responsible for providing such services as contracting and handling substantially all interactions with its participating healthcare providers. The financial terms of the BlueCard Program are described generally below. Individual circumstances may arise that are not directly covered by this description; however, in those instances, our action will be consistent with the spirit of this description.

a. ***Liability Calculation Method Per Claim***

The calculation of the Covered Person's liability on Claims for Covered Services processed through the BlueCard Program will be based on the lower of the participating healthcare provider's billed covered charges or the negotiated price made available to Claim Administrator by the Host Blue.

The calculation of Client's liability on Claims for Covered Services processed through the BlueCard Program will be based on the negotiated price made available to Claim Administrator by the Host Blue. Sometimes, this negotiated price may be greater than or equal to billed charges. Examples of this are (i) when a Host Blue has negotiated with its participating healthcare provider(s) an inclusive allowance (e.g., per case or per day amount) for specific healthcare services, and (ii) when such negotiated price is necessary or appropriate, as determined by the Host Blue, to provide for a Host Blue's geographic access or availability of particular types of health care services.

Host Blues may use various methods to determine a negotiated price, depending on the terms of each Host Blue's healthcare provider contracts. The negotiated price made available to Claim Administrator by the Host Blue may represent a payment negotiated by a Host Blue with a healthcare provider that is one of the following:

(1) an actual price. An actual price is a negotiated payment without any other increases or decreases, or

(2) an estimated price. An estimated price is a negotiated payment reduced or increased by a percentage to take into account certain payments negotiated with the provider and other Claim- and non-Claim-related transactions. Such transactions may include, but are not limited to, anti-fraud and abuse recoveries, provider refunds not applied on a Claim-specific basis, retrospective settlements, and performance-related bonuses or incentives, or

(3) an average price. An average price is a percentage of billed covered charges representing the aggregate payments negotiated by the Host Blue with all of its healthcare providers or a similar classification of its providers and other Claim- and non-Claim-related transactions. Such transactions may include the same ones as noted above for an estimated price.

Host Blues using either an estimated price or an average price may, in accordance with Inter-Plan Programs policies, prospectively increase or reduce such prices to correct for over- or underestimation of past prices (i.e., prospective adjustments may mean that a current price reflects additional amounts or credits for Claims already paid to providers or anticipated to be paid to or received from providers). However, the amount paid by the Covered Person and Client is a final price; no future price adjustment will result in increases or decreases to the pricing of past Claims. The BlueCard Program requires that the price submitted by a Host Blue to Claim Administrator is a final price irrespective of any future adjustments based on the use of estimated or average pricing.

If a Host Blue uses either an estimated price or an average price on a Claim, the Host Blue is required to hold any difference between the amount paid to the provider and the amount that Client pays in a variance account, pending settlement with its participating healthcare providers. Because all amounts paid are final, neither variance account funds held to be paid, nor the funds expected to be received, are due to or from Client. Such payable or receivable would be eventually exhausted by healthcare provider settlements and/or through prospective adjustment to the negotiated prices. *Some Host Blues may retain interest earned, if any, on funds held in variance accounts.*

In some instances federal law or the laws of a small number of states require Host Blues either (i) to use a basis for determining Covered Person's liability for Covered Services that does not reflect the entire savings realized, or expected to be realized, on a particular Claim or (ii) to add a surcharge.

Should either federal law or the law of the state in which healthcare services are accessed mandate liability calculation methods that differ from the negotiated price methodology or require a surcharge, Claim Administrator would then calculate Covered Person's liability and Client's liability in accordance with applicable law.

b. ***Return of Overpayments***

Under the BlueCard Program, recoveries from a Host Blue or its participating healthcare providers can arise in several ways, including, but not limited to, anti-fraud and abuse recoveries, healthcare provider/hospital bill audits, credit balance audits, utilization review refunds, and unsolicited refunds. In some cases, the Host Blue will engage a third party to assist in identification or collection of recovery amounts. The fees of such a third party may be charged to the Client. Recovery amounts determined in the ways noted above will be applied so that corrections will be made, in general, on either a Claim-by-Claim or prospective basis.

Unless otherwise agreed to by the Host Blue, Claim Administrator may request adjustments from the Host Blue for full refunds from healthcare providers due to the retroactive cancellation of membership but only for one year after the date of the Inter-Plan financial settlement process for the original Claim. In some cases, recovery of Claim payments associated with a retroactive cancellation may not be possible if, as an example, the recovery conflicts with the Host Blue's state law or healthcare provider contracts or would jeopardize the Host Blue's relationship with its healthcare providers.

c. ***BlueCard Program Fees and Compensation***

Client understands and agrees to reimburse Claim Administrator for certain fees and compensation which Claim Administrator is obligated under the BlueCard Program to pay to the Host Blues, to the Blue Cross and Blue Shield Association (BCBSA), and/or to BlueCard Program vendors, as described below. Fees and compensation under the BlueCard Program may be revised in accordance with the Program's standard procedures for revising such fees and compensation, which do not provide for prior

approval by Client. Such revisions typically are made annually as a result of Program policy changes and/or vendor negotiations. These revisions may occur at any time during the course of a given calendar year, and they do not necessarily coincide with Client's benefit period under this Agreement.

Claim Administrator will charge these fees as follows:

It is expected that, unless the number of Client's Blue enrolled contracts falls below 50,000, that the access fee and all other BlueCard Program-related fees are included in Claim Administrator's Administrative Charge set forth in the Agreement's Fee Schedule.

In the event that the number of Client's Blue enrolled contracts falls below Redacted, only the BlueCard Program access fee may be charged separately each time a Claim is processed through the BlueCard Program. If one is charged, it will be a percentage of the discount/differential Claim Administrator receives from the Host Blue, based on the current rate in accordance with the Program's standard procedures for establishing the access fee rate. The access fee will not exceed Redacted for any Claim. In this situation the access fee is set forth in the Agreement's Fee Schedule. All other BlueCard Program-related fees will then be factored into Claim Administrator's determination of its general administrative fee, also set forth in the Agreement's Fee Schedule.

(1) BlueCard Program Access Fees

A BlueCard Program access fee may be charged only if the Host Blue's arrangement with its healthcare provider prohibits billing Covered Persons for amounts in excess of the negotiated payment. However, a healthcare provider may bill for non-covered healthcare services and for Covered Person cost sharing (for example, deductibles, copayments, and/or coinsurance) related to a particular Claim.

(2) How the BlueCard Program Access Fee Affects Client

When Claim Administrator is charged a BlueCard Program access fee, Claim Administrator may pass the charge along to Client as a Claim expense or as a separate amount. The access fee will not exceed Redacted for any Claim. If Claim Administrator receives an access fee credit, Claim Administrator will give Client a Claim expense credit or a separate credit. Instances may occur in which the Claim payment is zero or Claim Administrator pays only a small amount because the amounts eligible for payment were applied to patient cost sharing (such as a deductible or coinsurance). In these instances, Claim Administrator will pay the Host Blue's access fee and pass it along to Client as stated above even though Client paid little or had no Claim liability.

16.3 *Negotiated National Account Arrangements*

As an alternative to the BlueCard Program, some of Client's Covered Persons' Claims for Covered Services may be processed through a negotiated National Account arrangement with a Host Blue. Pursuant to such negotiated arrangements, the Host Blue(s) [has/have] agreed to provide, on the Claim Administrator's behalf, Claim Payments and certain administrative services for those Covered Persons of the Client receiving Covered Services in the state and/or service area of the Host Blues. Pursuant to the agreement between the Claim Administrator and the Host Blues, the Claim Administrator has agreed to reimburse each Host Blue for all Claim Payments made on the Claim Administrator's behalf for those Covered Persons of the Client receiving Covered Services in the state and/or service area of such Host Blue.

If Claim Administrator and Client have agreed that (a) Host Blue(s) shall make available (a) custom healthcare provider network(s) in connection with this Agreement, then the terms and conditions set forth in Claim Administrator's negotiated National Account arrangement(s) with such Host Blue(s) shall apply, unless otherwise agreed in the Agreement's Fee Schedule. In negotiating such arrangement(s), Claim Administrator is not acting on behalf of or as an agent for Client, Client's Plan or Client's Covered Persons.

a. *Covered Person and Client Liability Calculation*

Covered Person liability calculation will be based on the lower of either billed covered charges or negotiated price (refer to the description of negotiated price under 16.2.a., BlueCard Program) made available to Claim Administrator by the Host Blue that allows Client's Covered Persons access to negotiated participation agreement networks of specified participating healthcare providers outside of Claim Administrator's service area.

Client's liability calculation will be based on the negotiated price (refer to the description of negotiated

price under 16.2.a., BlueCard Program).

Client also acknowledges that pursuant to the Host Blue's contracts with Host Blues' participating Providers, under certain circumstances described therein, the Host Blue (i) may receive substantial payment from Host Blues' participating Providers with respect to services rendered to such persons for which the Host Blue was initially obligated to pay the Host Blues' participating Providers, (ii) may pay Host Blues' participating Providers more or less than their billed charges for services, by discounts or otherwise, or (iii) may receive from Host Blues' participating Providers other allowances under the Host Blue's contracts with them. One example of this is quality improvement programs/payments.

If charged by the Host Blue to Claim Administrator, Client shall reimburse Claim Administrator for any payments made to the Host Blue, unless otherwise set forth in the Agreement's Fee Schedule, including "claim-like" charges, which are those charges for payments to Host Blues' participating Providers on other than a fee for services basis which include, but are not limited to, incentive payments and capitations.

The Client acknowledges that, in negotiating the Administrative Charge set forth in the Agreement's Fee Schedule, it has taken into consideration that, among other things, the Host Blue may receive such payments, discounts and/or other allowances during the term of its agreement with the Claim Administrator. Further, all amounts payable by Covered Person and Client shall be calculated on the basis described in this subsection, irrespective of any separate financial arrangement between the Host Blue's participating Provider that rendered the applicable Covered Service and the Host Blue other than the negotiated price as described in this subsection.

b. ***Fees and Compensation***

Client understands and agrees to reimburse Claim Administrator for certain fees and compensation which Claim Administrator is obligated under applicable Inter-Plan Programs requirements to pay to the Host Blues, to the Blue Cross and Blue Shield Association, and/or to Inter-Plan Programs vendors. Fees and compensation under applicable Inter-Plan Programs may be revised in accordance with the Programs' standard procedures for revising such fees and compensation, which do not provide for prior approval by Client. Such revisions typically are made annually as a result of Inter-Plan Programs policy changes and/or vendor negotiations. These revisions may occur at any time during the course of a given calendar year, and they do not necessarily coincide with Client's benefit period under this Agreement.

In addition, the participation agreement with the Host Blue may provide that Claim Administrator must pay an administrative and/or a network access fee to the Host Blue, and Client further agrees to reimburse Claim Administrator for any such applicable administrative and/or network access fees. For this type of negotiated participation arrangement, any such administrative and/or network access fees will not be greater than the comparable fees that would be charged under the BlueCard Program.

Claim Administrator will charge these fees as follows:

It is expected that the access fee and all other Negotiated National Account Arrangement-related fees are included in Claim Administrator's Administrative Charge set forth in the Agreement's Fee Schedule.

Client acknowledges that Host Blues may have contracts with certain Providers in their service areas ("Host Blues' participating Providers") for the provision of, and payment for, health care services. As a result of these contracts with their Providers, Host Blues are able to make provider networks available to persons and entities, including Claim Administrator, entitled to health care benefits under various health policies and contracts to which the Host Blue is a party. Such network availability extends to Covered Persons covered under the Agreement.

All other Inter-Plan Program fees related to this negotiated National Account arrangement are factored into Claim Administrator's determination of its Administrative Charge, also set forth in the Agreement's Fee Schedule.

The Claim Administrator hereby informs the Client, and the Client acknowledges, that the Claim Administrator's, the Host Blues' participating Provider contracting arrangements, operational practices and procedures, and the policies and procedures governing software used to process Claims for services rendered by the Claim Administrator's Providers and the Host Blues' participating Providers may result in

minor deviations in Claim processing and/or pricing of Claims for some services. From time-to-time, Claim Administrator, Host Blues and their respective vendors may receive compensation in connection with services provided by Claim Administrator to our group customers, which are not necessarily passed on to our group customers or to members. Additional information about these types of fees, the amount of these fees and the sources of these fees is available upon request.

16.4 ***Non-Participating Healthcare Providers Outside Claim Administrator's Service Area***

a. ***Covered Person Liability Calculation***

(1) In General

When Covered Services are provided outside of Claim Administrator's service area by non-participating healthcare providers, the amount(s) a Covered Person pays for such services will be calculated using the methodology described in the Agreement for non-Participating providers located inside our service area. The Covered Person may be responsible for the difference between the amount that the non-participating healthcare 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, Claim Administrator may, but is not required to, in its sole and absolute discretion, negotiate a payment with such non-participating healthcare provider on an exception basis.

b. ***Fees and Compensation***

Client understands and agrees to reimburse Claim Administrator for certain fees and compensation which Claim Administrator is obligated under applicable Inter-Plan Programs requirements to pay to the Host Blues, to the Blue Cross and Blue Shield Association, and/or to Inter-Plan Programs vendors. Fees and compensation under applicable Inter-Plan Programs may be revised in accordance with the specific Program's standard procedures for revising such fees and compensation, which do not provide for prior approval by Client. Such revisions typically are made annually as a result of Inter-Plan Programs policy changes and/or vendor negotiations. These revisions may occur at any time during the course of a given calendar year, and they do not necessarily coincide with Client's benefit period under this Agreement.

In addition, Claim Administrator must pay an administrative fee to the Host Blue, and Client further agrees to reimburse Claim Administrator for any such administrative fee as set forth below.

Claim Administrator will charge these fees as follows:

All fees related to Claims for Covered Services delivered by non-participating healthcare providers outside Claim Administrator's service area are factored into Claim Administrator's determination of its Administrative Charge, which is set forth in the Agreement's Fee Schedule.

SECTION 17: MEDICARE SECONDARY PAYER ("MSP") INFORMATION REPORTING

17.1 Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA) (P.L.110-173) adds new mandatory reporting requirements for group health plan ("GHP") arrangements. The parties agree that the Claim Administrator as the Responsible Reporting Entity ("RRE") under these new requirements is required to report information to the Centers for Medicare & Medicaid Services ("CMS") about individuals enrolled in the GHP who are also covered by Medicare so that CMS and the Claim Administrator can effectively coordinate health care payments consistent with the Medicare Secondary Payer ("MSP") rules.

17.2 The Client hereby authorizes and directs the Claim Administrator to disclose to CMS periodically, information pertaining to Medicare–eligible Covered Persons under the Plan.

17.3 The Client agrees that the Claim Administrator's ability to make accurate primary/secondary MSP determinations depends on the breadth and accuracy of the Claim Administrator's files concerning Covered Persons and the number of individuals employed by the Client. The Client agrees to use its best efforts in responding promptly and accurately to the Claim Administrator's requests for information including, but not limited to, information contained on the Employer Acknowledgement Form ("EAF") to be provided to the Claim Administrator by the Client on at least an annual basis, and more frequently, if the information provided on the last EAF received by the Claim Administrator changes, or as requested by the Claim

Administrator; and to require and facilitate its Covered Persons' cooperation in responding promptly and accurately to such requests.

17.4 Further, to assure the continuing accuracy of the Claim Administrator's files, the Client agrees that it is the Client's responsibility to notify the Claim Administrator promptly, via submission of an EAF and such other means as may be required for such continuing accuracy, of any change in the number of individuals employed by the Client or status of its employees that might affect the order of payment under the MSP statute, such as information regarding working–aged persons who retire and changes in the number of individuals employed by the Client that place it in, or take it out of, the scope of the MSP statute. The Client acknowledges and agrees that the Claim Administrator will be using the information provided by the Client and Covered Persons to update the Claim Administrator's files, and will also forward this information to CMS so that CMS can revise its file to reflect relevant changes in primary/secondary status.

17.5 Disclosure Statement: The Client acknowledges that the Claim Administrator has furnished it with a copy of a pamphlet entitled "Information Regarding the Medicare Secondary Payer Statute" (also referred to as the "Disclosure Statement"), prepared by the Blue Cross and Blue Shield Association and reviewed by CMS, which administers Medicare.

SECTION 18: REIMBURSEMENT PROVISION

Applicable only if this service is elected in the Fee Schedule specifications of the most current Exhibit 4 - ASO BPA

18.1 If a Covered Person incurs expenses for sickness or injury that occurred due to the negligence of a third party and benefits are provided for Covered Services described in the Plan, the following provisions will apply:

a. The Claim Administrator on behalf of the Client has the right to reimbursement for all benefits the Claim Administrator provided from any and all damages collected from the third party for those same expenses whether by action at law, settlement, or compromise, by the Covered Person, the Covered Person's parents, if the Covered Person is a minor, or the Covered Person's legal representative as a result of that sickness or injury, in the amount of the total Eligible Charge or Provider's Claim Charge for Covered Services for which the Claim Administrator has provided benefits to the Covered Person, reduced by any Average Discount Percentage ("ADP") applicable to the Covered Person's Claim or Claims.

b. The Claim Administrator is assigned the right to recover from the third party, or his or her insurer, to the extent of the benefits the Claim Administrator provided for that sickness or injury.

18.2 The Claim Administrator shall have the right to first reimbursement out of all funds the Covered Person, the Covered Person's parents, if the Covered Person is a minor, or the Covered Person's legal representative is or was able to obtain for the same expenses for which the Claim Administrator has provided benefits as a result of that sickness or injury. The Covered Person is required to furnish any information or assistance or provide any documents that the Claim Administrator may reasonably require in order to obtain its rights under this provision. This provision applies whether or not the third party admits liability.

SECTION 19: MEMBER DATA SHARING

A Covered Person may, under certain circumstances, as specified below, apply for and obtain, subject to any applicable terms and conditions, replacement coverage. The replacement coverage will be that which is offered by the Plan, or, if Covered Person does not reside in the Plan service area, by the Host Blue(s) whose service area covers the geographic area in which the Covered Person resides. The circumstances mentioned above may arise from involuntary termination of Covered Person's health coverage sponsored by the Client but solely as a result of a reduction in force, plan/office closing(s) or group health plan termination (in whole or in part). As part of the overall plan of benefits that Client offers to, a Covered Person, if the Covered Person does not reside in the Plan's service area, the Plan may facilitate a Covered Person's right to apply for and obtain such replacement coverage, subject to applicable eligibility requirements, from the Host Blue in which the Covered Person resides. To do this, the Client may (1) communicate directly with the Covered Persons and/or (2) provide the Host Blues whose service area covers the geographic area in which a Covered Person resides, with a

Covered Person's personal information and may also provide other general information relating to Covered Person's coverage under the Plan and which the Client has with Claim Administrator to the extent reasonably necessary to enable the relevant Host Blues to offer a Covered Person coverage continuity through replacement coverage.

EXHIBIT 3
RECOVERY LITIGATION AUTHORIZATION

The Client hereby acknowledges and agrees that the Claim Administrator may, at its election, pursue claims of the Client and/or the Plan, which are related to claims that the Claim Administrator pursues on its own behalf, subject to the following terms and conditions:

1. The Claim Administrator shall have the right to select and retain legal counsel.
2. Any lawsuit filed or arbitration initiated by the Claim Administrator will be done in the name of the Claim Administrator for its own benefit, as well as on behalf of the Client and possibly other parties. The Claim Administrator will not cause any litigation to be filed or arbitration to be initiated in the name of the Client and/or the Plan without the Client's express advance consent. With such permission, any such litigation can be filed or arbitration initiated in the name of the Client and/or the Plan with attorneys identified as counsel for the Client or in the name of two or more parties, including the Client and the Claim Administrator, with attorneys identified as counsel for the Client, the Claim Administrator and possibly other parties.
3. The parties agree to cooperate with each other in pursuit of recovery efforts pursuant to the provisions of this Exhibit, including providing appropriate authority to communicate with the Client concerning issues pertaining to any class actions and pursuant to which the Client specifically declines representation by class litigation counsel.
4. The Claim Administrator shall control any recovery strategy and decisions, including decisions to mediate, arbitrate or litigate.
5. The Claim Administrator shall have the exclusive right to approve any and all settlements of any claims being mediated, arbitrated or litigated.
6. Any and all recoveries, net of all investigative and other expenses relating to the recovery, including costs of settlement, mediation, arbitration or litigation including attorney's fees, made through any means pursuant to the provisions of this Exhibit, including, but not limited to, settlement, mediation, arbitration or trial, will be prorated based upon each party's percentage interest in the recoverable compensatory monetary damages, which allocation shall be done by the Claim Administrator on any reasonable basis it deems appropriate.
7. Any and all information, documents, communications or correspondence provided to or obtained by attorneys from either party, as well as communications, correspondence, conclusions and reports by or between attorneys and either party, shall be and are intended to remain privileged and confidential. Each party intends that the attorney–client and work product privileges shall apply to all information, documents, communications, correspondence, conclusions and reports to the full extent allowed by state or federal law. The Claim Administrator shall be permitted to make such disclosures of such privileged and confidential information to law enforcement authorities as it deems necessary or appropriate in its sole discretion. The Client shall not waive the attorney–client privilege or otherwise disclose privileged or confidential information received in connection with the provisions of this Exhibit or cooperative efforts pursuant to the provisions of this Exhibit without the express written consent of the Claim Administrator.
8. The discharge of attorneys by one party shall not disqualify or otherwise ethically prohibit the attorneys from continuing to represent the other party pursuant to the provisions of this Exhibit.
9. Nothing in the provisions of this Exhibit shall require the Claim Administrator to assert any claims on behalf of the Client and/or the Plan.
10. Nothing in the provisions of this Exhibit and nothing in attorneys' statements to either party and/or the Plan will be construed as a promise or guarantee about the outcome of any particular litigation, mediation, arbitration or settlement negotiation; therefore, the Client acknowledges that the efforts of the Claim Administrator may not result in recovery or in full recovery in any particular case.
11. The terms and conditions described herein shall survive the expiration or termination of the Agreement; however, nothing herein shall require the Claim Administrator to assert any claims on the Client's and/or the Plan's behalf following the termination of the Agreement. If the Agreement is terminated after the Claim

Administrator has asserted a claim on behalf of the Client and/or the Plan but before any recovery, the Claim Administrator may continue to pursue the claim or discontinue the claim.

12. If the Client should desire to participate in a class or multi-district settlement rather than defer to the Claim Administrator, the Client may reverse the exercise of discretion authorized herein by affirmatively opting into a class settlement and by notifying the Claim Administrator of its decision in writing, immediately upon making such determination as provided for under Section 26 NOTICES of the Agreement.
13. The Client further acknowledges and agrees that, unless it notifies the Claim Administrator to the contrary in writing as provided for under Section 26 NOTICES of the Agreement, it consents to the terms and conditions of this Exhibit and authorizes the Claim Administrator, on behalf of the Client and/or the Plan, consistent with Section 2 above to:
    a. Pursue claims that the Claim Administrator pursues on its own behalf in class action litigation, federal multi-district litigation, or otherwise, including, but not limited to, antitrust, fraud, unfair and deceptive business or trade practice claims pursuant to and in accordance with the provisions of this Exhibit effective immediately;
    b. Opt out of any class action settlement or keep the Client and/or the Plan in the class, if the Claim Administrator believes it is in the best interest of the parties to do so;
    c. Investigate and pursue recovery of monies unlawfully, illegally or wrongfully obtained from the Plan.
14. The Client further acknowledges and agrees that the Claim Administrator's decision to pursue recovery in connection with particular claims shall be in the Claim Administrator's discretion and the Claim Administrator does not enter into this undertaking as a fiduciary of the Plan or its Covered Persons, but only in connection with its undertaking to pursue recovery of claims of the Client and/or the Plan when, as, and if, the Claim Administrator determines that such claims may be pursued in the common interest of the parties.
15. The parties agree in the event that the language in the Agreement shall be in conflict with this Exhibit, the provisions of this Exhibit shall prevail.

EXHIBIT 4
ASO BENEFIT PROGRAM APPLICATION ("ASO BPA")

EXHIBIT 5: COBRA HEALTH BENEFITS CONTINUATION COVERAGE

1. DEFINITIONS

In the event that there is a conflict between the definitions set forth below and those found under the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA") or under the Internal Revenue Code of 1986, and the regulations thereunder, as may be amended, the statutory definitions shall control.

1.1 **"Health Benefits Continuation Coverage"** shall mean the administrative services Claim Administrator offers to assist the Client in fulfilling its responsibilities under the Consolidated Omnibus Budget Reconciliation Act of 1985.

1.1A **"Client"** means Catholic Health Initiatives, any predecessor thereto, its successor or assigns, permitted pursuant to Section 14.4 in the Agreement or any corporation resulting in any manner from a reorganization of the Employer or any individual, firm or corporation which shall assume the Health Benefits Continuation Coverage obligations of the Employer.

1.2 **"COBRA"** shall mean the Consolidated Omnibus Budget Reconciliation Act of 1985, as may be amended.

1.3 **"Continuation of Coverage Provisions"** shall mean continuation of group health care coverage provisions mandated by COBRA.

1.4 **"Covered Employee"** shall mean an individual who is *(or was)* provided coverage under the Plan by virtue of the individual's employment or previous employment with an Employer.

1.5 **"Qualified Beneficiary"** shall mean:

A. In general, the term **"Qualified Beneficiary"** shall mean, with respect to a Covered Employee under the Plan, any individual who, on the day before the qualifying event for that employee, is a beneficiary under the Plan:

1. as the spouse of the Covered Employee, or
2. as the dependent child of the Covered Employee.

B. In the case of a qualifying event which is caused by termination *(other than by reason for such* employee's *gross misconduct)*, or reduction of hours, of the Covered Employee's employment, the term **"Qualified Beneficiary"** includes the Covered Employee.

1.6 **"Qualifying Event"** shall mean, with respect to any Covered Employee, any of the following events which, but for the continuation coverage required, would result in the loss of coverage of a Qualified Beneficiary:

A. The death of the Covered Employee;

B. The termination (other than by reason of such employee's gross misconduct) or reduction of hours, of the Covered Employee's employment;

C. The divorce or legal separation of the Covered Employee from the employee's spouse;

D. The Covered Employee becoming entitled to benefits under Title XVIII of the Social Security Act;

E. A dependent child ceasing to be a dependent child under the generally applicable requirements of the Plan; or

F. A determination made under the Social Security Act that the Covered Employee is disabled.

1.7 **"Applicable Premium"** shall mean the amount a Plan will require a Qualified Beneficiary to pay, for any period of COBRA continuation coverage, that does not exceed one hundred and Redacted of the applicable premium for that period or does not exceed one hundred and Redacted of the applicable premium after the 18th month of coverage for Qualified Beneficiaries eligible for extended

coverage due to disability. The applicable premium is defined in Section 4980B(f)(4) of the Internal Revenue Code of 1986.

1.8 **"Employer"** means the Client, along with various other affiliates, subsidiaries, divisions or similar which have employees, and which entity is either (i) designated by the Client to the Claim Administrator either for services under this Agreement or (ii) is a participating employer under the Plan with respect to a Covered Employee as determined by the Client.

1.9 **"Plan Administrator"** shall have the meaning given the term **"administrator"** by Section 3(16)(a) of the Employee Retirement Income Security Act of 1974.

2. SERVICES TO BE PROVIDED BY CLAIM ADMINISTRATOR

During the term of this Agreement, Claim Administrator will perform such services as are set forth in Schedule I attached hereto and made a part hereof.

3. RESPONSIBILITIES OF THE CLIENT

3.1 The Client retains full and final authority and responsibility with respect to compliance with COBRA Continuation of Coverage Provisions and except as provided in Article IV of this Exhibit, the Client shall have the sole responsibility for and shall bear the entire cost of compliance with all federal, state and local rules and laws including, but not limited to: any licensing; filing; reporting and disclosure requirements as they may apply to its Health Benefits Continuation Coverage or COBRA Continuation Provisions; and all costs, expenses and fees relating thereto.

3.2 Subject to the terms of 5.3 of the Agreement, the Client shall undertake the defense of any action against it and/or Claim Administrator and shall be responsible for the costs of defense; provided, however, that Claim Administrator shall have the option, at its sole discretion, to employ attorneys selected by it to defend any such action, the costs and expenses of which shall be the responsibility of the Client.

3.3 It is understood by The Client that COBRA imposes penalties on an employer or Plan Administrator who fails to accurately comply with the COBRA Continuation of Coverage Provisions. Subject to the terms of 5.3 of the Agreement it is further understood by the Client that Claim Administrator shall in no way be responsible for any said penalties nor does Claim Administrator agree to be liable for damages resulting from any said penalties which may be imposed on the Client or Plan Administrator for non-compliance of COBRA Continuation of Coverage Provisions. The penalties may include, but are not limited to: loss of federal tax deduction for expenses paid or incurred for any Plan maintained by the Client; failure to notify the employee of continuation rights, either initially or upon a Qualifying Event resulting in a penalty payment of up to Redacted per Qualified Beneficiary per day of delay; and highly compensated individuals who participate in a Plan for which The Client fails to follow the COBRA requirements may not be permitted to exclude from income the amount contributed by the Client in his or her behalf for such coverage.

3.4 The Client hereby agrees to identify the employee who shall act as the sole contact between the Client and Claim Administrator in regard to COBRA Health Benefits Continuation Coverage matters under this Agreement.

3.5 The Client hereby agrees to be solely responsible for providing the initial notice regarding Health Benefits Continuation Coverage under COBRA and for providing and updating their Summary Plan Descriptions regarding COBRA.

3.6 Unless an insurance policy issued by Claim Administrator is in force, The Client understands that Claim Administrator does not insure or underwrite the liability of the Client for the Health Benefits Continuation Coverage it offers pursuant to COBRA. The Client retains the ultimate responsibility for claims made under the Health Benefits Continuation Coverage and all expenses incident to the Health Benefits Continuation Coverage, except as specifically assumed in this Agreement by Claim Administrator.

3.7 The Client shall furnish on a timely basis to Claim Administrator certain information concerning the Client's Plan descriptions and employees and dependents covered under the Health Benefits Continuation Coverage including Qualified Beneficiaries entitled to the Health Benefits Continuation Coverage as may from time to time be required by Claim Administrator for the performance of its duties including, but not limited to, the following:

All documents by which the Health Benefits Continuation Coverage is established and any amendments or changes to the Health Benefits Continuation Coverage as may from time to time be adopted including thirty *(30)* days prior written notification to Claim Administrator when the Client plans a reduction in force, lay-off, strike, or shutdown or filing for bankruptcy, or makes changes to any of the following: its Health Benefits Continuation Coverage; benefit pricing; or benefit carriers.

All data as may be required by Claim Administrator regarding the Qualified Beneficiaries who are to be covered under this Agreement.

a. Such data may include, without limitation, a list of Qualified Beneficiaries who are to be covered under this Agreement, and completed Health Benefits Continuation Coverage applications.

Further, the Client will notify Claim Administrator of the effective date of coverage for all Qualified Beneficiaries who are to be covered under this Agreement. Clerical errors or delays in keeping or reporting data relative to coverage under this Agreement will not invalidate coverage which would otherwise be validly in force or continue coverage which would otherwise validly terminate. However, the Client is liable for any benefits paid for a terminated Qualified Beneficiary if the Client had not timely notified Claim Administrator as required by COBRA of such Qualified Beneficiary's termination or ineligibility under COBRA.

b. All such notification by the Client to Claim Administrator must be furnished on forms or in a format approved by Claim Administrator and must include all information reasonably required by Claim Administrator to effect such changes.

Such information as to Health Benefit Continuation Coverage benefits as will enable Claim Administrator to accurately prepare any reports required under this Agreement. The Client, furthermore, shall use its best efforts to cooperate with and assist Claim Administrator as applicable, in the performance of its duties hereunder.

4. RESPONSIBILITIES OF CLAIM ADMINISTRATOR

4.1 Claim Administrator is empowered to act on behalf of the Client in connection with the Health Benefits Continuation Coverage only as expressly stated in this Agreement or as mutually agreed to in writing by the parties hereto.

4.2 Claim Administrator shall have no responsibility for the compliance of the Health Benefits Continuation Coverage or COBRA Continuation of Coverage Provisions with any applicable federal, state or local rule or law.

4.3 Claim Administrator shall be responsible for expenses arising out of its performance of the services described in Schedule I.

4.4 Claim Administrator hereby agrees to assume full responsibility for timely and complete notice to Qualified Beneficiaries of their respective rights under COBRA provided that the Plan Administrator has given timely and complete notice of the Qualifying Event to Claim Administrator. Notification shall be made in accordance with the notice and time requirements specified in the Consolidated Omnibus Budget Reconciliation Act of 1985. Upon notice of a Qualifying Event from the Plan Administrator, Claim Administrator will provide a notification package to the Qualified Beneficiary.

5. TERM AND TERMINATION OF COBRA SERVICES

5.1 This Exhibit shall run concurrent with the Agreement and shall terminate when the Agreement terminates, subject to Run-Out provisions. In the event of such termination Claim Administrator agrees to use its best efforts to assist the Client in notifying Qualified Beneficiaries, transferring data, files, and all other relevant information to the Client or its delegate. Unless agreed otherwise in writing by the parties, in the event of such termination, the Client shall have responsibility for current and future COBRA Qualified Beneficiaries Applicable Premium billing and collection services and all other responsibilities contained in this Exhibit.

5.2 In the event that the Client ceases to have an obligation under COBRA to provide Health Benefit Continued Coverage to all covered employees and all Qualified Beneficiaries, the Client will provide Claim Administrator with at least ten *(10)* days advance written notice of the cessation of its obligations. Upon receipt of such notice, Claim Administrator at its sole option, has the right to terminate this Agreement upon ten *(10)* days written notice to the Client. In the event of such termination by Claim Administrator, the Client shall immediately have complete responsibility for current and future COBRA Qualified Beneficiaries Applicable Premium billing and collection services and all other responsibilities contained in this Agreement. Further, in the event of such termination, the Client agrees to notify all Qualified Beneficiaries.

5.3 Termination of COBRA services by either the Client or Claim Administrator shall not terminate any other terms and/or conditions of this Agreement unless provided in this Agreement.

6. NOTICES

All notices, directions or requests under this Exhibit shall be in writing and shall either be delivered or mailed to the parties as follows.

If to the Claim Administrator:

Health Care Service Corporation,
P.O. Box 1180
Marion, IL 62959-7680

or if to the Client:

The Client address indicated on Exhibit 4, the Benefit Program Application ("BPA").

SCHEDULE I

Claim Administrator will perform the following services:

1. Claim Administrator will provide notice to Qualified Beneficiaries of their COBRA rights.
2. Claim Administrator will, within the time frames required by COBRA, produce and mail monthly COBRA premium bills for the Qualified Beneficiaries.
3. Claim Administrator will post premium payments received.
4. Claim Administrator will produce and mail late and/or insufficient premium notices within the time frames required by COBRA, when appropriate, that advise Qualified Beneficiaries that they are in jeopardy of losing their Health Benefits Continuation Coverage.
5. Where premiums are not paid in full or in a timely fashion as defined by COBRA, Claim Administrator will produce and mail a cancellation letter. Unless otherwise agreed to in writing by the parties, Claim Administrator will deem payments that are less than Redacted of the premium to be insufficient and cancel coverage.
6. Claim Administrator will send out conversion letters 90 days prior to the end of eligibility period.
7. Claim Administrator will respond to written or phone inquiries relating to COBRA.
8. Claim Administrator will, within 14 days after receipt of the enrollment form from the Qualified Beneficiary, produce and mail the initial COBRA benefit continuation billing.
9. Claim Administrator will, upon receipt of an enrollment form and initial premium payment, update membership for that Qualified Beneficiary. Once premiums have been received, claims will be processed through normal claims processing channels.
10. Claim Administrator will on a monthly basis furnish a check payable to the Client in the amount of COBRA premiums received less COBRA Administration fees described in Schedule II. A detailed report of premiums collected broken down by individual carrier(s) will accompany this remittance.

SCHEDULE II

Administrative Fee

The Client will pay a separate and distinct Administrative Fee to Claim Administrator as payment for the Administrative Services Claim Administrator provides under this Agreement. This Administrative Fee will be due and payable as follows:

1. The Client will pay Claim Administrator Redacted monthly administrative fee. The sum of Redacted will be deducted from the monthly remittance to the Client pursuant to Schedule I, paragraph 10. If the Redacted fee exceeds the amount of premium received, the excess will be due and payable to Claim Administrator upon receipt of a monthly invoice.

2. The Client will pay Claim Administrator a sum of Redacted per Qualified Beneficiary on a monthly basis as the payment for the billing and Applicable Premium collection services Claim Administrator provides under this Agreement. The sum of Redacted per Qualified Beneficiary per month will be deducted from the monthly remittance to the Client pursuant to Schedule I, paragraph 10. If the Redacted per Qualified Beneficiary per month fee exceeds the amount of premium received, the excess will be due and payable to Claim Administrator upon receipt of a monthly invoice.

3. The Client will pay Claim Administrator a sum of Redacted per Qualified Beneficiary for each notice to Qualified Beneficiaries of their COBRA rights. The sum of Redacted per Qualified Beneficiary notice will be deducted from the monthly remittance to the Client, pursuant to Schedule I, paragraph 10. If the Redacted per Qualified Beneficiary notice fee exceeds the amount of premium received, the excess will be due and payable to Claim Administrator upon receipt of a monthly invoice.

4. The Client will pay Claim Administrator a sum of Redacted per hour for any system programming costs associated with non-standard administration services. The sum of C Redacted Redacted per hour will be deducted from the monthly remittance to the Client pursuant to Schedule I, paragraph 10. If the One Hundred Dollars *($100.00)* per hour fee exceeds the amount of premium received, the excess will be due and payable to Claim Administrator upon receipt of a monthly invoice.

C.P. v. Blue Cross Blue Shield of Illinois
USDC (W.D. Wash.), No. 3:20-cv-06145-RJB

CONFIDENTIAL EXHIBIT

Filed Under Seal
Pursuant to Protective Order (Dkt. No. 25)

Exhibit Q

HONORABLE JUDGE ROBERT J. BRYAN

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF WASHINGTON
AT TACOMA

C. P., by and through his parents, Patricia Pritchard and Nolle Pritchard; and PATRICIA PRITCHARD, Plaintiff, vs. BLUE CROSS BLUE SHIELD OF ILLINOIS, Defendants.	Case No. 3:20-cv-06145-RJB **FIFTH SUPPLEMENTAL RESPONSES AND OBJECTIONS TO PLAINTIFFS' SECOND DISCOVERY REQUESTS TO DEFENDANT BLUE CROSS AND BLUE SHIELD OF ILLINOIS**

TO: Plaintiffs C. P., Patricia Pritchard, and Nolle Pritchard.

AND TO: SIRIANNI YOUTZ SPOONEMORE HAMBURGER PLLC and LAMBDA LEGAL DEFENSE AND EDUCATION FUND, INC., their attorneys.

Pursuant to Federal Rules of Civil Procedure 26, 33, and 34, Defendant Blue Cross Blue Shield of Illinois ("BCBSIL") hereby objects and responds to Plaintiffs' Second Discovery Requests (the "Requests") as follows:

A. GENERAL OBJECTIONS

1. BCBSIL objects to the Requests to the extent they are overly broad, unduly burdensome, oppressive, redundant, vague, ambiguous, and/or seek to impose on BCBSIL obligations greater than or different from those imposed by the Federal Rules of Civil Procedure.

2. BCBSIL objects to the Requests to the extent they impose a burden on it that is

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1420 FIFTH AVENUE, SUITE 3700
SEATTLE, WA 98101
(206) 626-7713 FAX: (206) 260-8946

disproportionate to the needs of the litigation.

3. BCBSIL interprets the Requests as excluding documents and information subject to the attorney-client privilege, work-product privilege, joint-defense/common-interest privilege, and any other applicable privileges or protections.

5. BCBSIL objects to the Requests to the extent they require BCBSIL to use more than reasonable diligence in preparing their objections and responses based on an examination of those files that reasonably may be expected to yield responsive information and an inquiry of those persons who reasonably may be expected to possess responsive information.

6. BCBSIL objects to the Requests to the extent the discovery sought is unreasonably cumulative, duplicative, or obtainable from some other source that is more convenient, less burdensome, or less expensive, including if the discovery sought is already in the Plaintiffs' possession.

7. BCBSIL objects to each and every Request to the extent it seeks to require BCBSIL to identify or produce documents not currently in their possession, custody, or control, on the grounds that such a request seeks to require more of BCBSIL than any obligation imposed by law, would subject it to unreasonable and undue annoyance, oppression, burden, and expense, or would seek to impose upon it an obligation to discover information or materials from third parties or sources that are equally accessible to the Plaintiffs.

8. BCBSIL objects to the Requests to the extent they seek information outside the applicable three-year statute of limitations for Plaintiffs' Section 1557 claims. *See Smith v. Highland Hosp. of Rochester*, No. 17-CV-6781-CJS, 2018 WL 4748187, at *3 (W.D.N.Y. Oct. 2, 2018); *Solis v. Our Lady of the Lake Ascension Cmty. Hosp., Inc.*, No. CV 18-56-SDD-RLB, 2020 WL 2754917, at *4 (M.D. La. May 27, 2020); *Ward v. Our Lady of the Lake Hosp., Inc.*, No. CV 18-00454-BAJ-RLB, 2020 WL 414457, at *2 (M.D. La. Jan. 24, 2020); RCW 4.16.080(2). Moreover, Plaintiffs' class claims, added via amended complaint, do not relate back to the filing of the initial complaint because BCBSIL was not put on sufficient notice at the time that Plaintiffs intended to seek relief on a class-wide basis. *See McClelland v. Deluxe Fin. Servs.,*

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SEATTLE, WA 98101
(206) 626-7713 FAX: (206) 260-8946

Inc., 431 F. App'x 718, 731 (10th Cir. 2011); *Corns v. Laborers Int'l Union of N. Am.*, No. 09-CV-4403 YGR, 2014 WL 1319363, at *5 (N.D. Cal. Mar. 31, 2014) (finding the notice requirement unmet where the original complaint did not give "clear notice" of plaintiff's intent to allege and certify a class); *Perry v. Beneficial Finance Co. of N.Y.*, 81 F.R.D. 490, 495 (W.D.N.Y. 1979) (amended complaint adding class claims did not relate back to initial individual complaint). Nonetheless, per the agreement between the parties and for discovery purposes only, BCBSIL will conduct and produce discovery from November 23, 2016 to the present.

10. BCBSIL incorporates by reference these "General Objections" into each of the Specific Responses and Objections set forth below, as if fully set forth therein

B. OBJECTIONS TO INSTRUCTIONS

1. BCBSIL objects to Instruction One because it purports to require BCBSIL to provide documents or information outside of its own possession, custody or control. BCBSIL will interpret these Requests to require BCBSIL to draw upon the information reasonably ascertainable to it, in accordance with the Federal Rules of Civil Procedure.

2. BCBSIL objects to Instruction Two because it purports to require BCBSIL to provide documents or information outside of its own possession, custody or control. BCBSIL will interpret these Requests to require BCBSIL to draw upon the information reasonably ascertainable to it, in accordance with the Federal Rules of Civil Procedure.

C. OBJECTIONS TO DEFINITIONS

1. BCBSIL objects to the terms "Defendant," "you" or "your," as overly broad and as calling for information outside of its own possession, custody, or control. BCBSIL also objects that these terms as defined seek information protected by the attorney-client privilege, work product doctrine, or any other applicable privilege or protection.

2. BCBSIL further objects that the term "Plan," as defined, fails to identify a specific policy year. BCBSIL interprets this term to mean the Summary Plan Description, with an effective

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SEATTLE, WA 98101
(206) 626-7713 FAX: (206) 260-8946

date of January 1, 2019, attached as Appendix A to the Amended Complaint (Doc. 38, the "Complaint").

D. REQUESTS FOR ADMISSION

REQUEST FOR ADMISSION NO. 1: Admit that there are at least 40 persons who fit the class definition found at paragraph 91 of the Amended Complaint (Dkt. No. 38).

INITIAL ANSWER: BCBSIL objects to this Interrogatory in that the class definition is vague, ambiguous and not easily ascertainable. BCBSIL is still investigating this request and will supplement this response upon competition of the investigation.

SUPPLEMENTAL ANSWER: BCBSIL objects that the class definition found at Paragraph 91 of the Amended Complaint is vague, ambiguous, and not easily ascertainable. BCBSIL specifically objects that the proposed class definition hypothetically includes all individuals who "will be participants" and who "will be denied pre-authorization of coverage."

Notwithstanding the foregoing objections, BCBSIL admits that there are at least 40 persons who may fit the class definition found at paragraph 91 of the Amended Complaint.

E. INTERROGATORIES

INTERROGATORY NO. 6: Please identify any other plans for which BCBSIL administers a gender-affirming care exclusion.

INITIAL ANSWER: BCBSIL objects to this Interrogatory as overly broad, unduly burdensome, and not reasonably calculated to lead to the discovery of admissible evidence in seeking "any other plans" for which BCBSIL administers a "gender-affirming care exclusion," without regard to the materiality of such plans to the fact as issue in this lawsuit as alleged in the Complaint.

Notwithstanding the foregoing objections, BCBSIL states that it will produce responsive Documents sufficient to show the relevant language and number of ERISA self-funded group health plans pursuant to Rule 33(d) of the Federal Rules of Civil Procedure.

SUPPLEMENTAL ANSWER: BCBSIL objects to this Interrogatory as overly broad,

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1420 FIFTH AVENUE, SUITE 3700
SEATTLE, WA 98101
(206) 626-7713 FAX: (206) 260-8946

unduly burdensome, and not reasonably calculated to lead to the discovery of admissible evidence in seeking "any other plans" for which BCBSIL administers a "gender-affirming care exclusion," without regard to the materiality of such plans to the fact as issue in this lawsuit as alleged in the Complaint.

Notwithstanding the foregoing objections, BCBSIL preliminarily states that there are 398 ERISA self-funded group health plans for which BCBSIL administers a gender-affirming care exclusion. Discovery is ongoing.

SECOND SUPPLEMENTAL ANSWER: *See* revised Addendum A.

THIRD SUPPLEMENTAL ANSWER: BCBSIL incorporates by references its prior and supplemental responses to Interrogatory No. 6. BCBSIL further states that of the 398 ERISA self-funded group health plans for which BCBSIL administers a gender-affirming care exclusion, some employers who offer a plan containing a gender-affirming care exclusion offer one or more plans in the same year that do not contain a gender-affirming care exclusion. *See, e.g.*, BCBSIL_CP_0020053-BCBSIL_CP_0020593.

INTERROGATORY NO. 7: Please identify the total population of enrollees, by year, in the CHI Plan and each of the plans identified in the responses to Interrogatories Nos. 3 and 6.

INITIAL ANSWER: BCBSIL incorporates by reference its responses and objections to Interrogatory Nos. 3 and 6. Notwithstanding the foregoing objections, BCBSIL states that it will

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SEATTLE, WA 98101
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meet and confer with Plaintiffs regarding the relevance of this request to the allegations in the complaint.

SUPPLEMENTAL ANSWER: BCBSIL states that the average number of enrollees in the CHI Medical Plan is as follows:

January 2016-December 2016	35,802
January 2017-December 2017	34,437
January 2018-December 2018	34,224
January 2019-December 2019	34,883
January 2020-December 2020	37,641
January 2021-December 2021	37,222

See BCBSIL_CP_0010824.

INTERROGATORY NO. 8: Please identify the total number of unique enrollees in each plan administered by BCBSIL that contains a gender-affirming care exclusion as identified in response to Interrogatory No. 6, or an exclusion that is the same or similar to the Transgender Reassignment Surgery exclusion as identified in response to Interrogatory No. 3, who have received a denial based on such exclusion from BCBSIL at any time since November 23, 2014.

INITIAL ANSWER: BCBSIL incorporates by reference its responses and objections to Interrogatory Nos. 3 and 6. BCBSIL further objects to the term "same or similar" as vague and ambiguous. BCBSIL also objects to the time frame set forth in this Interrogatory as seeking

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SEATTLE, WA 98101
(206) 626-7713 FAX: (206) 260-8946

irrelevant information beyond the applicable statute of limitations. For the reasons stated above, BCBSIL will conduct and produce discovery from November 23, 2016 to the present.

Notwithstanding the foregoing objections, BCBSIL states that it will produce responsive Documents sufficient to show the requested information from November 23, 2016 to the present, to the degree it exists.

SUPPLEMENTAL ANSWER: BCBSIL incorporates by reference its responses and objections to Interrogatory Nos. 3 and 6. BCBSIL further objects to the term "same or similar" as vague and ambiguous. BCBSIL also objects to the time frame set forth in this Interrogatory as seeking irrelevant information beyond the applicable statute of limitations. For the reasons stated above, BCBSIL will conduct and produce discovery from November 23, 2016 to the present.

Notwithstanding the foregoing objections, BCBSIL preliminarily states that of the ERISA self-funded group health plans BCBSIL administers, there are approximately 505 unique members of 200 plans who have received a denial based on such an exclusion, for a total claim count of 1,952 claims and a total billed charges amount of $1,326,779.00. BCBSIL reasonably anticipates that these numbers are overinclusive. Discovery is ongoing, and BCBSIL will supplement these preliminary numbers as its internal review and investigation proceeds.

INTERROGATORY NO. 9: For each of the plans identified in response to Interrogatories Nos. 3 and 6, please identify all individuals who participated in any way in the creation, drafting and/or preparation of the Benefit Program Application provision on coverage of treatment for gender dysphoria and/or the gender-affirming care exclusion, whether employed by BCBSIL or another entity.

ANSWER: BCBSIL incorporates by reference its responses and objections to Interrogatory Nos. 3 and 6. BCBSIL objects that the terms "creation" and "preparation" are vague

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SEATTLE, WA 98101
(206) 626-7713 FAX: (206) 260-8946

and ambiguous. Notwithstanding the foregoing objections, BCBSIL states that it will meet and confer with Plaintiffs regarding the relevance of this request to the allegations in the complaint.

INTERROGATORY NO. 10: To the extent that BCBSIL's response to Request for Admission No. 1 is not a complete admission, please identify the complete factual bases for BCBSIL's denial, either in whole or in part, including the source of the factual bases for the denial.

ANSWER: BCBSIL has admitted Request for Admission No. 1.

F. REQUESTS FOR PRODUCTION

REQUEST FOR PRODUCTION NO. 12: All contracts, Benefit Program Applications or other kinds of applications or agreements between BCBSIL and any other entity, including the self-funded plans and/or the self-funded plans' sponsors, pertaining to the plans identified in response to Interrogatories Nos. 3 and 6 in effect as of January 1, 2014, up to and including the present.

INITIAL RESPONSE: BCBSIL incorporates by reference its responses and objections to Interrogatory Nos. 3 and 6. BCBSIL objects to this Request as unduly burdensome and not reasonably calculated to lead to the discovery of admissible evidence in seeking "all contracts, Benefit Program Applications or other kinds of applications or agreements" between BCBSIL and "any other entity," without regard to the materiality of such documents to the facts at issue in this lawsuit. For example, this Request as drafted could encompass agreements between BCBSIL and a whole number of third parties that have nothing to do with coverage for any beneficiaries. BCBSIL further objects to the time frame set forth in this Request as seeking irrelevant information beyond the applicable statute of limitations.

Notwithstanding the foregoing objections, BCBSIL states that it will meet and confer with Plaintiffs regarding the relevance of this request to the allegations in the complaint.

SUPPLEMENTAL RESPONSE: BCBSIL has produced its Administrative Services Agreement, *see* BCBSIL_CP_0003912. BCBSIL has also produced a number of responsive

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SEATTLE, WA 98101
(206) 626-7713 FAX: (206) 260-8946

Benefit Program Applications from 2013-2021, *see, e.g.*, BCBSIL_CP_0008556; BCBSIL_CP_0010652; BCBSIL_CP_0011135; BCBSIL_CP_ 0011147; BCBSIL_CP_ 0008567; BCBSIL_CP_0010664; BCBSIL_CP_0008419; BCBSIL_CP_0010632; and BCBSIL_CP_ 0010621.

REQUEST FOR PRODUCTION NO. 13: All documents, emails, and other communications relating to covering or excluding treatment related to gender dysphoria and/or a gender-affirming care exclusion with regards to any plan identified in response to Interrogatories Nos. 3 and 6, including but not limited to, treatment with puberty blockers, hormone treatment, and/or surgery.

RESPONSE: BCBSIL incorporates by reference its responses and objections to Interrogatory Nos. 3 and 6. BCBSIL also objects to this Interrogatory to the extent it seeks information protected by the attorney-client privilege, the work product doctrine, and/or other applicable privileges. BCBSIL further objects to this Request as unduly burdensome and not reasonably calculated to lead to the discovery of admissible evidence in seeking "all documents, emails, and other communications" without regard to the materiality of such documents to the facts at issue in this lawsuit. For example, this Request as drafted could encompass documents, emails, and communications related to the plans identified in response to Interrogatory Nos. 3 and 6 but which do not directly concern treatment for gender dysphoria and/or a gender-affirming care exclusion.

Notwithstanding the foregoing objections, BCBSIL states that it will meet and confer with Plaintiffs regarding the relevance of this request to the allegations in the complaint.

REQUEST FOR PRODUCTION NO. 14: To the extent not already provided, please produce all copies of the "Benefit Program Application" submitted to BCBSIL in relation to

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SEATTLE, WA 98101
(206) 626-7713 FAX: (206) 260-8946

any plan identified in response to Interrogatories No. 3 and 6, at any time since January 1, 2014.

RESPONSE: BCBSIL incorporates by reference its responses and objections to Interrogatory Nos. 3 and 6. BCBSIL further objects to the time frame set forth in this Request as seeking irrelevant information beyond the applicable statute of limitations.

Notwithstanding the foregoing objections, BCBSIL states that it will meet and confer with Plaintiffs regarding the relevance of this request to the allegations in the complaint.

REQUEST FOR PRODUCTION NO. 15: To the extent not already provided, please produce all documents relating to any plan identified in response to Interrogatories Nos. 3 and 6 which reflect any determination that BCBSIL could administer such plan in a manner that did not and/or does not comply with the Affordable Care Act's Section 1557, 42 U.S.C. § 18116.

RESPONSE: BCBSIL incorporates by reference its responses and objections to Interrogatory Nos. 3 and 6. BCBSIL also objects to this Request to the extent it implicates attorney-client privilege, work-product privilege, or any other applicable privileges or protections.

BCBSIL incorporates by reference its responses and objections to Interrogatory Nos. 3 and 6. Notwithstanding the foregoing objections, BCBSIL states that it will meet and confer with Plaintiffs regarding the relevance of this request to the allegations in the complaint.

DATED this 29th day of July, 2022.

KILPATRICK TOWNSEND & STOCKTON LLP

By *_/s/ Gwendolyn C. Payton_*

Gwendolyn C. Payton, WSBA No. 26752
gpayton@kilpatricktownsend.com
1420 Fifth Ave., Suite 3700
Seattle, WA 98101
Telephone: (206) 626-7714
Facsimile: (206) 623-6793

Counsel for Defendant Health Care Service

Corporation, a Mutual Legal Reserve Company, doing business in Illinois as Blue Cross and Blue Shield of Illinois

KILPATRICK TOWNSEND & STOCKTON LLP
1420 FIFTH AVENUE, SUITE 3700
SEATTLE, WA 98101
(206) 626-7713 FAX: (206) 260-8946

CONFIDENTIAL

CERTIFICATE OF SERVICE

I certify that on the date indicated below I caused a copy of the foregoing document, FIFTH SUPPLEMENTAL RESPONSES AND OBJECTIONS TO PLAINTIFFS' SECOND DISCOVERY REQUESTS TO DEFENDANT BLUE CROSS AND BLUE SHIELD OF ILLINOIS has been sent via e-mail to the following attorneys of record:

Eleanor Hamburger
SIRIANNI YOUTZ SPOONEMORE HAMBURGER
3101 WESTERN AVENUE STE 350
SEATTLE, WA 98121
206-223-0303
Fax: 206-223-0246
Email: ehamburger@sylaw.com

Jennifer C Pizer
LAMBDA LEGAL DEFENSE AND EDUCATION FUND, INC.
4221 WILSHIRE BLVD., STE 280
LOS ANGELES, CA 90010
213-382-7600
Email: jpizer@lambdalegal.org

Omar Gonzalez-Pagan
LAMBDA LEGAL DEFENSE AND EDUCATION FUND, INC. (NY)
120 WALL STREET
19TH FLOOR
NEW YORK, NY 10005
212-809-8585
Email: ogonzalez-pagan@lambdalegal.org

DATED this 29th day of July, 2022.

Kilpatrick, Townsend & Stockton LLP

By: */s/ Gwendolyn C. Payton*
Gwendolyn C. Payton, WSBA #26752
gpayton@kilpatricktownsend.com

Counsel for Defendant Health Care Service Corporation, a Mutual Legal Reserve Company, doing business in Illinois as Blue Cross and Blue Shield of Illinois

KILPATRICK TOWNSEND & STOCKTON LLP
1420 FIFTH AVENUE, SUITE 3700
SEATTLE, WA 98101
(206) 626-7713 FAX: (206) 260-8946

ADDENDUM A

Effective Date	Exclusion/Limitation Language
1/01/2017	["Exclusions - What is Not Covered"] "Gender reassignment Surgery (also referred to as transsexual Surgery, sex reassignment Surgery or intersex Surgery), including related services and supplies."
1/1/2019	["Exclusions"] "This Plan does not cover services, supplies or treatment relating to, arising out of, or given in connection with the following: . . . Treatment or services, except for the initial diagnosis, for a primary diagnosis of Mental Retardation, Learning, Motor Skills and Communication Disorders, Conduct Disorder, Dementia, Sexual, Paraphilia and Gender Dysphoria, and Personality Disorders, as well as other mental illnesses that will not substantially improve beyond the current level of functioning, or that are not subject to modification or management according to prevailing national standards of clinical practice, as reasonably determined by Blue Cross and Blue Shield of Illinois." ["Short Term Disability Benefits"] "This Plan will not cover any disability . . . a gender change, including, but not limited to, any operation, drug therapy or any other procedure related to a gender change." [“Long Term Disability Benefits"] "This Plan will not cover any disability: . . . a gender change, including, but not limited to, any operation, drug therapy or any other procedure related to a gender change."
1/01/2020	[GENDER REASSIGNMENT SURGERY] Benefits will be provided for Covered Services for gender reassignment the same as any other for persons 18 and older. Benefits for gender reassignment Surgery will be limited to a lifetime maximum of $75, 000. Gender reassignment Surgery will be provided when all of the following criteria are met: 1. The Individual is at least 18 years of age; 2. The individual has been diagnosed with the Gender Identity Disorder (GID) of transsexualism; 3. The individual has undergone a minimum of 12 months of continuous hormonal therapy when recommended by a mental health professional and such therapy is provided under the supervision of a Physician; 4. The individual has completed a minimum of 12 months of successful continuous full time real-life experience in their new gender, with no returning to their original gender; 5. A letter from the individual’s physician and mental health provider, who has treated the individual for a minimum of 18 months, documenting the treatment and that the treatment is Medically Necessary. Coverage will also be provided for cosmetic Surgery. The following surgeries

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	are considered cosmetic and will be covered for an individual who has undergone or is planning to undergo gender reassignment Surgery: 1. Reduction thyroid chondroplasty; 2. Liposuction; 3. Rhinoplasty; 4. Facial bone reconstruction; 5. Face lift; 6. Blepharoplasty; 7. Voice modification surgery; 8. Hair removal/hairplasty; and/or 9. Breast augmentation. However, no benefits will be provided for transportation or lodging expenses or for any reversal of gender reassignment Surgery. [EXCLUSIONS – WHAT IS NOT COVERED] • Transportation and lodging expenses for gender reassignment Surgery • Reversal of gender reassignment surgery.
1/1/2016	["What is Not Covered by the Medical Plan"] "Transsexual surgery or any treatment of gender identity disorders."
1/1/2013	[Gender Reassignment Surgery] “Benefit is provided to associates only. All of the following criteria must be met: - Associate is at least 18 years old; - Associate has met criteria for the diagnosis of "true" transsexualism, including: - A sense of estrangement from one's own body, so that any evidence of one's own biological sex is regarded as repugnant;- A stable transsexual orientation evidenced by a desire to be rid of one's genitals and to live in society as a member of the other sex for at least 2 years, that is, not limited to periods of stress; - Absence of physical inter-sex of genetic abnormality; - Does not gain sexual arousal from cross-dressing; - Life-long sense of belonging to the opposite sex and of having been born into the wrong sex, often since childhood; - Not due to another biological, chromosomal or associated psychiatric disorder, such as schizophrenia; - Wishes to make his or her body as congruent as possible with the preferred sex through surgery and hormone treatment; and - Associate has completed a recognized program of transgender identity treatment as evidenced by all of the following: - A qualified mental health professional*who has been acquainted with the member for at least 18 months recommends sex reassignment surgery documented in the form of a written comprehensive evaluation; - For genital surgical sex reassignment, a second concurring recommendation by another qualified mental health professional * must be documented in the form of a written expert opinion**;

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SEATTLE, WA 98101
(206) 626-7713 FAX: (206) 260-8946

-For genital surgical sex reassignment, member has undergone a urological examination for the purpose of identifying and perhaps treating abnormalities of the genitourinary tract, since genital surgical sex reassignment includes the invasion of, and the alteration of, the genitourinary tract (urological examination is not required for persons not undergoing genital reassignment);
- Associate has demonstrated an understanding of the proposed male-to-female or female-to-male sex reassignment surgery with its attendant costs, required lengths of hospitalization, likely complications, and post-surgical rehabilitation requirements of the planned surgery; - Psychotherapy is not an absolute requirement for surgery unless the mental health professional's initial assessment leads to a recommendation for psychotherapy that specifies the goals of treatment, estimates its frequency and duration throughout the real life experience (usually a minimum of 3 months);
- The associate has successfully lived and worked within the desired gender role full-time for at least 12 months(so-called real-life experience), without periods of returning to the original gender; and
- Unless medically contraindicated, associate has received at least 12 months of continuous hormonal sex reassignment therapy recommended by a mental health professional and carried out by an endocrinologist (which can be simultaneous with the real-life experience)."

"*At least one of the two clinical behavioral scientists making the favorable recommendation for surgical (genital) sex reassignment must possess a doctoral degree (e.g., Ph.D., Ed.D., D.Sc., D.S.W., Psy.D., or M.D.).
Note: Evaluation of candidacy for sex reassignment surgery by a mental health professional is covered under the member's medical benefit, unless the services of a mental health professional are necessary to evaluate and treat a mental health problem, in which case the mental health professional's services are covered under the associate's behavioral health benefit. Please check benefit plan descriptions."

**Either two separate letters or one letter with two signatures is acceptable.

"Notes:
(1) Medically necessary core surgical procedures for female to male persons include: mastectomy, hysterectomy, vaginectomy, salpingo-oophorectomy, metoidioplasty, phalloplasty, urethroplasty, scrotoplasty and placement of testicular prostheses, and erectile prostheses.
(2) Medically necessary core surgical procedure for male to female persons include: penectomy, orchidectomy, vaginoplasty, clitoroplasty, and labiaplasty.
(3) Rhinoplasty ,face-lifting, lip enhancement, facial bone reduction, blepharoplasty, breast augmentation, liposuction of the waist (body contouring), reduction thyroid chondroplasty, hair"

"Gender Reassignment Surgery- Travel & Lodging Gender reassignment surgery

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SEATTLE, WA 98101
(206) 626-7713 FAX: (206) 260-8946

	is performed at limited locations in the United States, and most patients will need to travel outside their immediate home area. If travel is required for surgery because it is not offered in your immediate home area, travel to an in-network surgery provider and lodging expenses will be reimbursed up to a maximum of $10,000. To be eligible for reimbursement: - Travel must be over 100 miles away from your home and must be by air, rail, bus or car. The $10,000 covers you and one caretaker to travel with you for in-network surgery only. - You are only allowed to travel in-network within the 48 contiguous United States. - Lodging expenses include hotel or motel room, car rental, tips and cost of meals while you are not hospitalized and for your caretaker. - Itemized receipts will be required."
1/1/2015	[Schedule of Benefits Gender Reassignment Surgery] LIFETIME MAXIMUM OF $75,000 PPO 85% after deductible 60% of eligible charges after deductible HRA 85% after deductible 60% of eligible charges after deductible HSA 85% after deductible 60% of eligible charges after deductible. Gender reassignment surgery benefits will be provided for covered services rendered to persons age 18 and over. Conditions for coverage apply: •The individual is at least 18 years of age• The individual has been diagnosed with the gender identity disorder (GID) of trans-sexualism •The individual has undergone a minimum of 12 months of continuous hormonal therapy when recommended by a mental health professional and provided under the supervision of a physician •The individual has completed a minimum of 12 months of successful continuous full time real-life experience in their new gender, with no returning to their original gender •A letter from the individual's physician or mental health provider documenting treatments and medical necessity [Exclusions] Benefits for gender reassignment surgery exclude transportation and lodging expenses, reversals, and surgeries that are considered to be cosmetic. The following surgeries are considered cosmetic and will not be covered for an individual who has undergone or is planning to undergo gender reassignment surgery: reduction thyroid, chondroplasty, liposuction, rhinoplasty, facial bone reconstruction, face lift, blepharoplasty, voice modification surgery, hair removal/hairplasty and breast augmentation. [STD Exclusions] Cosmetic surgery (defined as procedures or services that change or improve appearance without significantly improving physiological function) except for reconstructive surgery or gender reassignment surgery and the subsequent cosmetic surgery to enhance the transformation, as determined by Leave Administration and the medical plan.

KILPATRICK TOWNSEND & STOCKTON LLP
1420 FIFTH AVENUE, SUITE 3700
SEATTLE, WA 98101
(206) 626-7713 FAX: (206) 260-8946

6/1/2021	["Exclusions - What is Not Covered"] "Gender reassignment Surgery (also referred to as transsexual Surgery, sex reassignment Surgery or intersex Surgery), including related services and supplies." "["Exclusions - What is Not Covered"] Transgender Coverage"
1/1/2022	["Other Covered Services"] Gender reassignment—Benefits will be provided for services and supplies related to gender reassignment but excluding surgery.
1/1/2019	["Other Plan Exclusions and Limitations"] "Services related to gender reassignment"
1/1/2016	["Gender Reassignment Surgery"] "Benefits will be provided for the gender reassignment surgery for persons age 18 and over with a Gender Identity Disorder, undergone a minimum of 12 months of continuous hormonal therapy when recommended by a mental health professional and provided under the supervision of a physician. Benefits for gender reassignment will be limited to a lifetime maximum of $75,000." Gender Reassignment Surgery is covered; with the exception of the following: - Transportation and lodging expenses relating to gender reassignment surgery; - Reversals of gender reassignment Surgery.
1/1/2015	["Participating Provider"] "When you receive Covered Services for gender reassignment Surgery (also referred to as transsexual Surgery, sex reassignment Surgery or intersex Surgery) and counseling and related services and supplies, from a Participating Provider, benefits will be provided at 90% of the Maximum Allowance or 90% of the Eligible Charge after you have met your program deductible. However, benefits for gender reassignment Surgery, including counseling, related services and supplies, are subject to a lifetime maximum of $75,000." ["Non-Participating Provider"] "When you receive Covered Services for gender reassignment Surgery (also referred to as transsexual Surgery, sex reassignment Surgery or intersex Surgery) and counseling and related services and supplies, from a Non- Participating Provider, benefits will be provided at 70% of the Maximum Allowance or 70% of the Eligible Charge after you have met your program deductible. However, benefits for gender reassignment Surgery, including counseling, related services and supplies, are subject to a lifetime maximum of $75,000."

KILPATRICK TOWNSEND & STOCKTON LLP
1420 FIFTH AVENUE, SUITE 3700
SEATTLE, WA 98101
(206) 626-7713 FAX: (206) 260-8946

	[EXCLUSIONS – WHAT IS NOT COVERED] "Reversal of gender reassignment surgery (also referred to as transsexual Surgery, sex reassignment Surgery or intersex Surgery), including related services and supplies."
1/1/2014	["Participating Provider"] "When you receive Covered Services for gender reassignment Surgery (also referred to as transsexual Surgery, sex reassignment Surgery or intersex Surgery) and counseling and related services and supplies, from a Participating Provider, benefits will be provided at 80% of the Maximum Allowance or 80% of the Eligible Charge after you have met your program deductible. However, benefits for gender reassignment Surgery, including counseling, related services and supplies, are subject to a lifetime maximum of $75,000." ["Non-Participating Provider"] "When you receive Covered Services for gender reassignment Surgery (also referred to as transsexual Surgery, sex reassignment Surgery or intersex Surgery) and counseling and related services and supplies, from a Non- Participating Provider, benefits will be provided at 60% of the Maximum Allowance or 60% of the Eligible Charge after you have met your program deductible. However, benefits for gender reassignment Surgery, including counseling, related services and supplies, are subject to a lifetime maximum of $75,000." ["Exclusions - What is Not Covered"] "Reversal of gender reassignment Surgery (also referred to as transsexual Surgery, sex reassignment Surgery or intersex Surgery), including related services and supplies."
1/1/2014	["Participating Provider"] "When you receive Covered Services for gender reassignment Surgery (also referred to as transsexual Surgery, sex reassignment Surgery or intersex Surgery) and counseling and related services and supplies, from a Participating Provider, benefits will be provided at 100% of the Maximum Allowance or 100% of the Eligible Charge after you have met your program deductible. However, benefits for gender reassignment Surgery, including counseling, related services and supplies, are subject to a lifetime maximum of $75,000." ["Non-Participating Provider"] "When you receive Covered Services for gender reassignment Surgery (also referred to as transsexual Surgery, sex reassignment Surgery or intersex Surgery) and counseling and related services and supplies, from a Non- Participating Provider, benefits will be provided at 70% of the Maximum Allowance or 70% of the Eligible Charge after you have met your program deductible.

KILPATRICK TOWNSEND & STOCKTON LLP
1420 FIFTH AVENUE, SUITE 3700
SEATTLE, WA 98101
(206) 626-7713 FAX: (206) 260-8946

	However, benefits for gender reassignment Surgery, including counseling, related services and supplies, are subject to a lifetime maximum of $75,000." ["Exclusions - What is Not Covered"] "Reversal of gender reassignment Surgery (also referred to as transsexual Surgery, sex reassignment Surgery or intersex Surgery), including related services and supplies."
1/1/2018	[EXCLUSIONS – WHAT IS NOT COVERED] "Reversal of gender reassignment surgery (also referred to as transsexual Surgery, sex reassignment Surgery or intersex Surgery), including related services and supplies."
1/1/2016	The following exclusions apply generally to all services, drugs and supplies for BCBSIL and CVS Caremark. Specific limitations and exclusions related to certain types of care also appear in the Schedule of Benefits. Please refer to the Schedule of Benefits for specific coverage, limitations and exclusions. *** 10. Charges for sex transformation surgery, hormones related to the surgery, and any related expenses.
1/1/2022	[Gender Reassignment Surgery] "Benefits will be provided for gender reassignment surgery for persons age 18 and over with gender dysphoria, Gender dysphoria (formerly known as 'gender identity disorder') is a condition recognized by the Diagnostic and Statistical Manual (DSM) of Mental Disorders and commonly known as transsexualism. The diagnostic criteria describe many individuals who experience dissonance between their sex at birth and personal gender identity, which is not the same as having ambiguous genitalia. Gender reassignment surgery-- also known as transsexual surgery or sex reassignment surgery-- and related services may be considered medically necessary when meeting the criteria for gender dysphoria listed below. Otherwise, gender reassignment surgery and related services will be considered not medically necessary. Benefits for gender reassignment surgery will be unlimited. Benefits for gender reassignment surgery are the same as benefits for any other condition. Benefits will be provided for Covered services rendered to persons age 18 and over. Criteria for Coverage of Gender Reassignment Surgery and Related Services: The individual being considered for surgery and related services must meet ALL the following criteria. The individual must have: Reached the age of majority- at least 18 years of age AND The capacity to make a fully informed decision and to consent for treatment; AND Been diagnosed with persistent, well-documented gender dysphoria, AND Undergone a minimum of 12 months of continuous hormonal therapy when recommended by a mental health professional and provided under the supervision of a physician. Completed a minimum of 12 months of successful continuous full time real−life experience in their new gender, with no returning

KILPATRICK TOWNSEND & STOCKTON LLP
1420 FIFTH AVENUE, SUITE 3700
SEATTLE, WA 98101
(206) 626-7713 FAX: (206) 260-8946

	to their original gender. A letter from the individual's physician or mental health provider documenting treatments and medical necessity. Has the required referrals prior to any surgery or related service(s): o Prior to feminizing or masculinizing hormonal therapy, one required referral from the individual's qualified mental health professionals competent in the assessment and treatment of gender dysphoria; and/or o Prior to breast/chest surgery, e.g., mastectomy, chest reconstruction, or breast augmentation, one required referral from the individual's qualified mental health professionals competent in the assessment and treatment of gender dysphoria; and/or o Prior to any genital surgery, e.g., hysterectomy, salpingooophorectomy, orchiectomy, and/or other genital reconstructive procedures, two separate required independent referrals (or one signed by both referring providers) from the individual's qualified mental health professionals competent in the assessment, treatment of gender dysphoria, and addressing the identical/same surgery to be performed. Gender Reassignment Surgeries and Related Services: Procedures or services to create and maintain gender specific characteristics (masculinization or feminization) as part of the overall desired gender reassignment services treatment plan may be considered medically necessary for the treatment of gender dysphoria ONLY. These procedures may include the following: Abdominoplasty; • Blepharoplasty; • Brow lift; • Calf implants; • Cheek implants; • Chin or nose implants; • External penile prosthesis (vacuum erection devices); • Face lift (rhytidectomy); • Facial bone reconstruction/sculpturing/reduction, includes jaw shortening; • Forehead lift or contouring; • Hair removal (may include donor skin sites) or hair transplantation (electrolysis or hairplasty); • Laryngoplasty; • Lip reduction or lip enhancement; • Liposuction/lipofilling or body contouring or modeling of waist, buttocks, hips, and thighs reduction; • Neck tightening; • Pectoral implants; • Reduction thyroid chondroplasty or trachea shaving (reduction of Adam's apple); • Redundant/excessive skin removal; • Rhinoplasty (nose correction); • Skin resurfacing; Benefits for gender reassignment surgery exclude: Transportation and lodging expenses, Reversals [Not payable under the plan] "Gender Reassignment Surgery is covered; with the exception of the following: Transportation and lodging expenses relating to gender reassignment surgery; reversals of gender reassignment surgery."
1/1/2016	["Specific Limits, Criteria and Exclusions"] Gender Identity Disorder Treatment Benefit Limits: Network only - 50% $75,000 per Member Lifetime Maximum Non-Network– 0% Includes psychotherapy, continuous hormone replacement(not oral – see Prescription Drug Details section) (including laboratory testing to monitor safety), Genital Surgery, Surgery to Change Secondary Sex Characteristics.

KILPATRICK TOWNSEND & STOCKTON LLP
1420 FIFTH AVENUE, SUITE 3700
SEATTLE, WA 98101
(206) 626-7713 FAX: (206) 260-8946

	Excludes:- reversal of genital surgery or reversal of surgery to revise secondary sex characteristics; -sperm preservation in advance of hormone treatment or gender surgery; -cryopreservation of fertilized embryos. - voice modification surgery; -facial feminization surgery, including but not limited to: facial bone reduction, face "lift", facial hair removal, and certain facial plastic procedures; -suction-assisted lipoplasty of the waist; -drugs for hair loss or growth;-drugs for sexual performance or Cosmetic purposes (except for hormone therapy described above); -voice therapy; and -transportation, meals, lodging or similar expenses. Criteria for Coverage of Continuous Hormone Replacement. In order to receive hormones (not oral– see Prescription Drug Section) of the desired gender, the Member must: - have a diagnosed Gender Identity Disorder; - be at least age 18; -demonstrate knowledge of what hormones medically can and cannot do and their social benefits and risks; and -have already had completed: - a documented real-life experience living as the desired gender of at least three months; and - a period of psychotherapy of a duration specified by the Mental Health Professional after the initial evaluation (usually a minimum of three months). Gender Identity Disorder means a disorder characterized by the following diagnostic criteria: -a strong and persistent cross-gender identification (not merely a desire for any perceived cultural advantages of being the other sex); -the member's persistent discomfort with his or her sex or sense of inappropriateness in the gender role of that sex; -the disturbance is not concurrent with a physical intersex condition; and -the disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning. Criteria for Coverage of Surgery. In order to receive Genital Surgery or Surgery to Change Secondary Sex Characteristics: -the Member must have a diagnosed Gender Identity Disorder;-the Surgery must be performed by a Provider at a Hospital or Alternate Facility with a history of treating persons with Gender Identity Disorder; - the treatment plan must conform to the World Professional Association for Transgender Health Association (WPATH, an advocacy group) standards; - the Member must be at least age 18 years or older for irreversible surgical interventions; - the Member must complete 12 months of Continuous Hormone Therapy for those without contraindications; and - the Member must complete 12 months of successful continuous full time real life experience in the desired gender. Genital Surgery means one of the following: complete hysterectomy, orchiectomy, penectomy, vaginoplasty, vaginectomy, clitoroplasty, labiaplasty, salpingo-oophorectomy, metoidioplasty, scrotoplasty, urethroplasty, placement of testicular prosthesis, phalloplasty.

KILPATRICK TOWNSEND & STOCKTON LLP
1420 FIFTH AVENUE, SUITE 3700
SEATTLE, WA 98101
(206) 626-7713 FAX: (206) 260-8946

1/1/2013	"Gender reassignment surgery – Benefits will be provided for gender reassignment Surgery for persons diagnosed with a Gender Identity Disorder and will be limited to a lifetime maximum of $75,000." "Gender reassignment Surgery is covered; with the exception of the following: ffl Transportation and lodging expenses relating to gender reassignment Surgery; ffl Reversals of gender reassignment Surgery; ffl Surgeries which a reconsidered to be cosmetic including, but not limited to, reduction tyroid chondroplasty, liposuction, rhinoplasty, facial bone reconstruction, face lift, blepharoplasty, voice modification Surgery, hair removal/hairsplasty, and breast augmentation."
1/1/2013	["Exclusions - What is not covered"] "Gender reassignment Surgery (also referred to as transsexual Surgery, sex reassignment Surgery or intersex Surgery), including related services and supplies. This exclusion includes medications, implants, hormone therapy, surgery, medical or psychiatric treatment."

KILPATRICK TOWNSEND & STOCKTON LLP
1420 FIFTH AVENUE, SUITE 3700
SEATTLE, WA 98101
(206) 626-7713 FAX: (206) 260-8946