

Marmon Healthcare Plan

Summary Plan Description – H

January 1, 2015

A message from

The Plan Administrator

This booklet describes the Marmon Healthcare Plan which is provided by your Employer 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 your Employer's Human Resources Department or the Claim Administrator.

Sincerely,
The Marmon Group LLC
Plan Administrator

IMPORTANT NOTICE

KNOW WHAT BENEFITS YOU MAY EXPECT FROM THE PLAN

LIMITED BENEFITS WILL BE PAID WHEN NON-PARTICIPATING PROVIDERS AND/OR NON-ADMINISTRATOR PROVIDERS ARE UTILIZED FOR SERVICES

Maximize the benefits received under the Plan by obtaining Covered Services from Participating Providers. They are In-Network Providers. Determine if the Provider is a Participating Provider by contacting the Claims Administrator using the toll free telephone number printed on your identification card. It is the responsibility of the covered individual or their representative, such as a parent or a legal guardian in the case of a covered Dependent, to determine if a Provider is a Participating Provider.

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 and/or Non-Administrator 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 should be aware that when you elect to utilize the services of a Non-Participating Provider or a Non-Administrator Provider for a Covered Service, benefit payments to such Non-Participating and/or Non-Administrator Providers are not based upon the amount billed. The basis of your benefit payment will be determined according to the Plan's benefit schedule and the definition of Eligible Charge or Maximum Allowance provided in the Definitions section of this benefit booklet. In some instances the Eligible Charge or Maximum Allowance considered for claims payment from the Plan may be the approved rate otherwise considered for purposes of Medicare. That rate is typically very much lower than the charges billed for the services. When applicable, the use of the Medicare rate as the basis for a claim payment applies without regard to the age of the individual who received the Covered Services.

So as to avoid unfortunate and potentially costly personal expenses for yourself and your family, prior to receiving services from a health care service Provider, determine if the Provider is part of the BCBS network or Providers. If not part of the BCBS network, ask the provider for an estimate of the cost of the services and what portion of those costs the Provider anticipates will be paid through the Plan. Remember, if the Provider is a Non-Administrator Provider, that is, the Provider has NO contractual arrangement with BCBS of IL or its affiliates, the Plan's reimbursement rate will be limited to the approved Eligible Charges or Maximum Allowance that would be paid through Medicare, even if you or the recipient of the services is not covered under the Medicare program. The difference between what is paid by the Plan and what is charged for the services is the responsibility of the recipient of the services or, in the case of a dependent, of the dependent's parents.

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.

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.

TABLE OF CONTENTS

BENEFIT HIGHLIGHTS – PLAN E	1
ELIGIBILITY - WAITING PERIOD – PREMIUM PAYMENT INFORMATION	5
DEFINITIONS SECTION.....	6
ELIGIBILITY & ENROLLMENT SECTION	21
ELIGIBILITY	21
ENROLLMENT	21
MEDICARE ELIGIBLE COVERED PERSONS	21
YOUR ID CARD	22
INDIVIDUAL COVERAGE	22
FAMILY COVERAGE	22
LIMITING AGE AND CHILDREN WITH DISABILITIES	22
CHANGING FROM INDIVIDUAL TO FAMILY COVERAGE or ADDING DEPENDENTS TO FAMILY COVERAGE	23
CHANGING FROM FAMILY TO INDIVIDUAL COVERAGE.....	23
MID-YEAR PLAN ELECTION CHANGES (E.g., Changing from Individual to Family Coverage, Adding Dependents to Family Coverage; Changing from Family to Individual Coverage)	23
“CHIPRA” Special Enrollment Opportunity	25
HIPAA SPECIAL ENROLLMENT	25
TERMINATION OF COVERAGE	28
CIRCUMSTANCES THAT MAY AFFECT BENEFITS.....	29
SPECIAL SITUATIONS -- EXTENSION OF COVERAGE	30
FAMILY AND MEDICAL LEAVE ACT OF 1993 (FMLA)	30
UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT (USERRA)	30
MEDICARE ELIGIBLE COVERED PERSONS	31
YOUR MSP RESPONSIBILITIES.....	31
SPECIAL ELECTION FOR EMPLOYEES AND SPOUSES AGE 65 AND OVER	32
UTILIZATION REVIEW PROGRAM.....	33
PREADMISSION REVIEW	33
CASE MANAGEMENT	34
LENGTH OF STAY/SERVICE REVIEW	34
MEDICALLY NECESSARY DETERMINATION	35
UTILIZATION REVIEW PROCEDURE.....	35
APPEAL PROCEDURE	36
FAILURE TO NOTIFY	36
MEDICARE ELIGIBLE MEMBERS.....	36
CLAIM ADMINISTRATOR’S MENTAL HEALTH UNIT	37
PREAUTHORIZATION REVIEW	37
MEDICALLY NECESSARY DETERMINATION	38
MENTAL HEALTH UNIT PROCEDURE	39
APPEAL PROCEDURE	39
FAILURE TO PREAUTHORIZE OR NOTIFY.....	40
INDIVIDUAL BENEFITS MANAGEMENT PROGRAM (“IBMP”).....	41
MEDICARE ELIGIBLE MEMBERS.....	41
THE PARTICIPATING PROVIDER OPTION.....	42
YOUR BENEFIT PERIOD.....	42
YOUR DEDUCTIBLE.....	42
FAMILY DEDUCTIBLE.....	42
HOSPITAL BENEFIT SECTION.....	43
INPATIENT CARE	43
BENEFIT PAYMENT FOR INPATIENT HOSPITAL COVERED SERVICES	44
OUTPATIENT HOSPITAL CARE	44
BENEFIT PAYMENT FOR OUTPATIENT HOSPITAL COVERED SERVICES	45
WHEN SERVICES ARE NOT AVAILABLE FROM A PARTICIPATING PROVIDER (HOSPITAL).....	46
PHYSICIAN BENEFIT SECTION.....	47

COVERED SERVICES	47
BENEFIT PAYMENT FOR PHYSICIAN SERVICES.....	51
OTHER COVERED SERVICES	55
BENEFIT PAYMENT FOR OTHER COVERED SERVICES.....	56
SPECIAL CONDITIONS AND PAYMENTS.....	59
HUMAN ORGAN TRANSPLANTS.....	59
SPECIAL NOTE – ORGAN TRANSPLANT RELATED BENEFIT EXCLUSIONS	60
CARDIAC REHABILITATION SERVICES.....	60
PREVENTATIVE CARE SERVICES.....	60
WELLNESS CARE	61
SKILLED NURSING FACILITY CARE	61
AMBULATORY SURGICAL FACILITY	62
MENTAL ILLNESS SERVICES AND SUBSTANCE USE DISORDER REHABILITATION	
TREATMENT	62
DETOXIFICATION	62
BARIATRIC SURGERY	62
MATERNITY SERVICE.....	62
INFERTILITY TREATMENT	63
TEMPOROMANDIBULAR JOINT DYSFUNCTION AND RELATED DISORDERS	63
MASTECTOMY-RELATED SERVICES.....	63
PAYMENT PROVISIONS	64
OUT-OF-POCKET EXPENSE LIMIT	64
EXTENSION OF BENEFITS IN CASE OF TERMINATION.....	65
HOSPICE CARE PROGRAM	66
OUTPATIENT PRESCRIPTION DRUG PROGRAM BENEFIT SECTION.....	67
PRIOR AUTHORIZATION REQUIREMENT	67
STEP THERAPY	68
SPECIALTY DRUG PROGRAM	68
COVERED SERVICES	68
HEARING CARE PROGRAM.....	70
BENEFITS FOR MEDICARE ELIGIBLE COVERED PERSONS	72
YOUR MSP RESPONSIBILITIES.....	72
SPECIAL ELECTION FOR EMPLOYEES AND SPOUSES AGE 65 AND OVER	72
EXCLUSIONS - WHAT IS NOT COVERED.....	74
COORDINATION OF BENEFITS SECTION	80
CONTINUATION COVERAGE RIGHTS UNDER COBRA	82
CLAIM FILING AND APPEALS PROCEDURES.....	85
FILING OUTPATIENT PRESCRIPTION DRUG CLAIMS	85
INTERNAL CLAIMS DETERMINATIONS AND APPEALS PROCESS.....	86
INITIAL CLAIMS DETERMINATIONS	86
INQUIRIES AND COMPLAINTS	87
CLAIM APPEAL PROCEDURES - DEFINITIONS	88
CLAIM APPEAL PROCEDURES	88
STANDARD EXTERNAL REVIEW.....	91
EXPEDITED EXTERNAL REVIEW.....	93
EXHAUSTION	94
GENERAL PROVISIONS	95
REIMBURSEMENT PROVISION.....	103
ERISA RIGHTS OF PLAN PARTICIPANTS.....	105
HIPAA NOTICE OF PRIVACY PRACTICES	107
GENERAL INFORMATION.....	112

BENEFIT HIGHLIGHTS – PLAN H

Your health care benefits are highlighted below. However, to fully understand your benefits, it is very important that you read this entire benefit booklet. Plan benefit limitations may apply which are not mentioned in this section.

---THE UTILIZATION REVIEW PROGRAM---

A special program designed to assist you in determining the course of treatment that will maximize your benefits under this benefit booklet.

Lifetime Maximum for all Benefits

Unlimited

Individual Coverage Deductible**

—	Participating Provider	\$1,500 per Benefit Period
—	Non-Participating and/or	
—	Non-Administrator Provider	\$1,500 per Benefit Period

Family Coverage Deductible**

—	Participating Provider	\$3,000 per Benefit Period
—	Non-Participating and/or	
—	Non-Administrator Provider	\$3,000 per Benefit Period

Individual Coverage Out-of-Pocket Expense Limit**

—	Participating Provider	\$3,000 per Benefit Period
—	Non-Participating Provider	\$6,000 per Benefit Period
—	Non-Administrator Provider	No limit

Family Coverage Out-of-Pocket Expense Limit**

—	Participating Provider	\$6,000 per Benefit Period
—	Non-Participating Provider	\$12,000 per Benefit Period
—	Non-Administrator Provider	No limit

Chiropractic and Osteopathic

Manipulation Benefit Maximum

20 visits per Benefit Period

Notice: Health services noted in this Highlights Section that are obtained from a Non-Participating Provider and/or a Non-Administrator Provider are subject to benefit levels based on the Eligible Charge or Maximum Allowance for the services. The Eligible Charge or Maximum Allowance could be limited to the reimbursement rate under Medicare, even though the recipient of the services is not covered under Medicare.

--- HOSPITAL BENEFITS---

Payment level for Covered Services from a

Participating Provider:

After Deductible

—	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:

After Deductible

—	Inpatient Covered Services	60% of the Eligible Charge
—	Outpatient Covered Services	60% of the Eligible Charge

Payment level for Covered Services from a

After Deductible

Non-Administrator Provider	60% of the Eligible Charge*
----------------------------	-----------------------------

Hospital Emergency Care

Payment level for Emergency Accident Care from either a

After Deductible

—	Participating	90% of the Eligible Charge
—	Non-Participating and/or	
—	Non-Administrator Provider	

Payment level for Emergency Medical Care from either a

After Deductible

—	Participating	90% of the Eligible Charge
—	Non-Participating and/or	90% of the Eligible Charge (*)
	Non-Administrator Provider	

* If you receive services from a Non-Administrator Provider and that Provider has no contractual relationship with BCBS of IL or one of its affiliates, the Eligible Charge or Maximum Allowance considered for the Plan's benefit determination may be limited to the then current reimbursement rates established under Medicare.

PHYSICIAN BENEFITS

Payment level for

Surgical / Medical Covered Services

After Deductible

— Participating

80% of the Maximum Allowance

— Non-Participating

60% of the Maximum Allowance (*)

Payment level for Emergency – Accident Care

After Deductible

90% of the Maximum Allowance

Payment level for Emergency – Medical Care

After Deductible

90% of the Maximum Allowance (*)

OTHER COVERED SERVICES

Payment level

After Deductible

80% of the Eligible Charge
or Maximum Allowance

HEARING BENEFITS

Benefit Payment Level – from a Participating Provider only

After Deductible

80% of the Usual & Customary Fee
(Hearing exams are limited to 1 per year)

Hearing Aid Maximum

1 per ear every 5 years

TELE-MEDICINE – MDLIVE

This is a telecommunication based program providing medical and/or behavioral consultation services. Contact MDLIVE via its website at www.MDLIVE.com or by telephone by calling 1-888-632-2738.

Medical consultation fee is \$40 per session

Behavioral consultation fee is \$85 for one hour

**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.**

(*) If you receive services from a Non-Administrator Provider and that Provider has no contractual relationship with BCBS of IL or one of its affiliates, the Eligible Charge or Maximum Allowance considered for the Plan's benefit determination may be limited to the then current reimbursement rates established under Medicare.

PRESCRIPTION DRUG PROGRAM BENEFITS

Payment Level – Participating Prescription Drug Provider	<u>After Deductible</u>
— Generic drugs and generic diabetic supplies	80% of the Eligible Charge per prescription
— Formulary brand name drugs and Formulary brand name diabetic	80% of the Eligible Charge per prescription
— Non-Formulary brand name drugs and Non-Formulary brand name diabetic supplies	80% of the Eligible Charge per prescription

Home Delivery Prescription Drug Program

Payment Level – Participating Prescription Drug Provider	<u>After Deductible</u>
— Generic drugs	80% of the Eligible Charge per prescription
— Formulary brand name drugs and all diabetic supplies	80% of the Eligible Charge per prescription
— Non-Formulary brand name drugs	80% of the Eligible Charge per prescription

Member Pay the Difference

Prescription drug benefits obtained under the Outpatient Prescription Drug Program will be governed by a claims protocol known as “Member Pay the Difference” which means that the benefit will be calculated based on the difference in the cost for prescriptions when a brand name drug has a generic equivalent.

Specialty Drugs

Benefits for prescription drugs that are listed as part of the Prime Therapeutics Specialty Drug Program will only be available under the terms of that Program through the Prime Specialty Pharmacy. Plan benefits for prescription drugs which are on the Specialty Drug listing will not be available if those prescription drugs are obtained from a source other than the Prime Specialty Pharmacy, nor will a benefit be available if such prescription drugs are obtained from a retail pharmacy. Contact Prime Specialty Pharmacy by calling 877-627-6337 for more information.

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

Plan benefits, if prescription drugs are obtained from a Non-Participating Drug Provider, are reduced in nature from those noted above and are described in the Out-Patient Prescription Drug Program section of this booklet. Obtain information about Participating Prescription Drug Providers by contacting the Claim Administrator website or by calling the toll-free number indicated on your Plan identification Card.

ELIGIBILITY - WAITING PERIOD – PREMIUM PAYMENT INFORMATION

The name of the Participating Employer is INSERT LEGAL COMPANY NAME

General Eligibility Rule

If you are a full-time employee of the Participating Employer, meaning you work on average at least thirty (30) or more hours per week and you are in an eligible classification of employees as noted in this portion of this booklet, you are eligible to participate in the Marmon Healthcare Plan following the Waiting Period noted below.

Eligible Employee Classification

The full-time employees of the Participating Employer who are eligible for participation in the Plan are as follows:

- INSERT classification of eligible employees

Waiting Period

The Participating Employer has established the following Waiting Period that an employee must complete prior to becoming eligible to participate in the Plan.

INSERT Waiting Period –See Suggestions in Cover Email

Coverage for eligible dependent family members begins when coverage for the employee begins, if the required premiums for coverage of dependents, paid through a payroll deduction has been authorized by the eligible employee.

Premium Payment

You must authorize payment of the health plan premium established by the Participating Employer for you and your Eligible Dependents, to qualify for coverage under the terms of the Plan. Payment of the premiums for active status employees is through a payroll deduction.

Spousal Surcharge

A Participating Employer may require an employee who is eligible for coverage under the Plan to pay an additional premium for such coverage, a “surcharge”, if the employee elects to cover his or her Spouse under the Plan and the Spouse has coverage available from his or her employer but declines such coverage, no matter what the reason for declining such coverage. The amount of the surcharge is at the discretion of the Participating Employer.

31 Calendar Days to Enroll

Without regard to the length of the Waiting Period for coverage under the Plan, a full-time employee potentially eligible for coverage under the Plan must apply for such coverage within 31 calendar days of his or her date of hire as a full-time employee unless the Participating Employer has communicated another enrollment rule.

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.

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.

ADOPTION AGREEMENT.....means the document by which a Participating Employer adopts the Plan as a means of providing health plan benefit coverage for certain of its eligible employees and their covered dependents.

ADVANCED PRACTICE NURSE.....means Certified Clinical Nurse Specialist, Certified Nurse-Midwife, Certified Nurse Practitioner or Certified Registered Nurse Anesthetist.

AMBULANCE TRANSPORTATION.....means local transportation in a specially equipped certified vehicle 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.

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.

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 Healthcare 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.

BENEFIT PERIOD.....means a period of one year which begins on January 1st of each year, except as otherwise stated in this booklet. 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.

CERTIFICATE OF CREDITABLE COVERAGE.....means a certificate disclosing information relating to your Creditable Coverage under a health care benefit program for purposes of reducing any Preexisting Condition exclusion imposed by any group health plan coverage, if applicable.

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
- (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
- (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
- (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; (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.

CHEMICAL DEPENDENCY RESIDENTIAL TREATMENT CENTER.....means an institution or facility licensed, certified, or approved as a chemical dependency treatment center by the appropriate state agency and is accredited by the Joint Commission on Accreditation of Health Care Organization (JCAHO), the Commission on the Accreditation of Rehabilitation Facilities (CARF), and/or the Council on Accreditation (COA) for the treatment of SUBSTANCE USE DISORDER.

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

CHIROPRACTOR.....means a duly licensed chiropractor.

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, 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.

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 of this benefit booklet regarding “The Claim Administrator’s Separate Financial Arrangements with Providers.”)

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 of this benefit booklet regarding “The Claim Administrator’s Separate Financial Arrangements with Providers.”)

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 to provide services to you at the time services are rendered.

CLINICAL PROFESSIONAL COUNSELOR.....means a duly licensed clinical professional counselor.

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.

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.

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.

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

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 Healthcare Plan begins which is your coverage effective date. The date your coverage ends is your coverage termination date.

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 (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 you.

DENTIST.....means a duly licensed dentist.

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 and electromyograms.

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.

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.

DURABLE MEDICAL EQUIPMENT PROVIDER.....means a duly licensed durable medical equipment provider.

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 you at the time Covered Services are rendered, such 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 you at the time Covered Services are rendered, will be the lesser of:

- (i) the Provider’s billed charges, or;
- (ii) the Claim Administrator non-contracting Eligible Charge. Except as otherwise provided in this section, the non-contracting Eligible Charge 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, the non-contracting Eligible Charge for Coordinated Home Care Program Covered Services will be 50% of the Non-Participating or Non-Administrator Provider’s standard billed 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 Non-Participating or Non-Administrator Providers will be 50% of the Non-Participating or Non-Administrator Provider’s standard billed 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 or Non-Administrator Providers which may also alter the 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 the Claims. The 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.

ELIGIBLE DEPENDENT.....means, unless otherwise provided in the Employer’s Adoption Agreement, your Spouse; natural children; step children, children who, before reaching the age of 26, are either adopted by the employee or placed in the employee’s home for adoption (such as under an interim court order of adoption or an order placing the child with the employee for adoption and vesting the employee with temporary care) and children for whom the employee is legal guardian. You must be covered under the Plan and you and your dependents must satisfy the requirements set forth in the Adoption Agreement in order for your dependents to be eligible. Dependent children with disabilities shall be eligible after the limiting age to the extent provided under **”LIMITING AGE AND CHILDREN WITH DISABILITIES”** below. Grandchildren, unless they are under the employee’s legal guardianship, and foster children are not eligible to participate in the Plan.

ELIGIBLE PERSON.....means an employee of the Employer and the Eligible Dependents of a covered employee of the Employer who meets the eligibility requirements for this health plan coverage, as described in the **“ELIGIBILITY & ENROLLMENT”** and **“ELIGIBILITY – WAITING PERIOD – PREMIUM PAYMENT INFORMATION”** sections of this benefit booklet. The rules governing an Eligible Person’s right to participate in the Plan, and his or her Waiting Period, are established in the Adoption Agreement. Independent contractors, leased employees or employees of a professional employee organization are not eligible to participate in this Plan. Eligibility for Medicaid or the receipt of Medicaid benefits will not be taken into account in determining eligibility. Grandchildren (unless they are under the Employee’s legal guardianship) and foster children are not eligible to participate in the Plan.

EMERGENCY ACCIDENT CARE.....means the initial Outpatient treatment of accidental injuries including related Diagnostic Services.

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 Disorder condition such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect that 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 and which has entered into an Adoption Agreement with the Plan Administrator to offer this Plan as an employee benefit. The term Employer in the context of this Plan also refers to a Participating Employer.

ENROLLMENT DATE.....means the first day of coverage under this health Plan or, if your Employer has a waiting period prior to your Coverage Date (the effective date of your coverage), the first day of the waiting period (that is the date your eligible employment begins).

ENROLLMENT PERIOD.....means the period specified in the Benefit Program Application during which you may apply for coverage if you did not apply prior to your Eligibility Date or if you did not apply for Family Coverage when eligible to do so. Eligibility Date is the 32nd day following your date of hire as an employee eligible to participate in the Plan.

ESSENTIAL HEALTH BENEFITS.....means ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance Use Disorder disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care, as defined in the Patient Protection and Affordable Care Act.

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

HEALTHCARE PLAN.....means the Marmon Healthcare Plan (“the Plan”) which is a plan, offered through an Employer, based on an agreement with the Plan Administrator, through which health plan benefits are provided to

eligible individuals. The Plan is a self-funded plan of benefits for which Blue Cross, Blue Shield of Illinois serves as the Claim Administrator.

HIPAA.....means the Health Insurance Portability and Accountability Act as amended.

HOME INFUSION THERAPY PROVIDER.....means a duly licensed home infusion therapy provider.

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.

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 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.

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 Healthcare Plan for yourself but not your spouse and/or dependents.

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

INVESTIGATIONAL or INVESTIGATIONAL SERVICES AND SUPPLIES.....means procedures, drugs, devices, services and/or supplies which (1) are provided or performed in special settings for research purposes or under a controlled environment and which are being studied for safety, efficiency and effectiveness, and/or (2) are awaiting endorsement by the appropriate National Medical Specialty College or federal government agency for general use by the medical community at the time they are rendered to you, and (3) specifically with regard to drugs, combination of drugs and/or devices, are not finally approved by the Food and Drug Administration at the time used or administered to you.

LIFETIME.....means the period of time an Eligible Person or his/her Eligible Dependents participate in this Plan or have participated in another health plan sponsored either by the Plan Sponsor or a Participating Employer.

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. All benefit payments for Covered Services rendered by Participating Professional Providers will be based on the Schedule of Maximum Allowances which these Providers have agreed to accept as payment in full. (b) For Non-Participating Professional Providers, the Maximum Allowance will be the lesser of:

- (i) the Provider's billed charges, or;
- (ii) the Claim Administrator 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, the non-contracting Maximum Allowance for Coordinated Home Care Program Covered Services will be 50% of the Non-Participating Professional Provider's standard billed 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 Maximum Allowance for Non-Participating Professional Providers will be 50% of the Non-Participating Professional Provider's standard billed 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 Maximum Allowance 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 the Claims. The 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.

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.

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. w1395 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. w1395 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 HEALTH RESIDENTIAL TREATMENT CENTER.....means an institution or facility appropriately licensed by the state and accredited by the Joint Commission on Accreditation of Health Care Organization (JCAHO), the American Association of Psychiatric Services for Children, the Commission on the Accreditation of Rehabilitation Facilities (CARF), and/or the Council on Accreditation (COA) for the treatment of MENTAL ILLNESS.

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

MENTAL ILLNESS.....means those illnesses classified as disorders in the current *Diagnostic and Statistical Manual of Mental Disorders* published by the American Psychiatric Association.

“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) Anorexia nervosa and bulimia nervosa.

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

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

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.

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.

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.

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 Rehabilitation Treatment in which patients spend days or nights.

PARTICIPATING EMPLOYER.....means a member of The Marmon Group of companies that has entered into an Adoption Agreement with the Plan Administrator to provide under the terms of this Plan, health plan benefits for its eligible employees, covered dependents, and retirees, if applicable.

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 any licensed establishment in which the profession of pharmacy is practiced.

PHYSICAL THERAPIST.....means a duly licensed physical therapist.

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.

PHYSICIAN ASSISTANT.....means a duly licensed physician assistant performing under the direct supervision of a Physician, Dentist or Podiatrist and billing under such Provider.

PLAN.....means the Marmon Healthcare Plan.

PLAN ADMINISTRATOR.....means The Marmon Group LLC.

PLAN SPONSOR.....means Marmon Holdings, Inc.

PODIATRIST.....means a duly licensed podiatrist.

PREAUTHORIZATION, PREAUTHORIZE or EMERGENCY MENTAL ILLNESS OR SUBSTANCE USE DISORDER ADMISSION REVIEW.....means a submission of a request to the Mental 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.

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.

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 a Pharmacy 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 services to you at the time you receive the services.

PSYCHOLOGIST.....means a Registered Clinical Psychologist.

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 SURGICAL ASSISTANT.....means a duly licensed certified surgical assistant, certified surgical technician, surgical assistant certified or registered nurse first assistant.

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.

RESIDENTIAL TREATMENT CENTER.....means a facility setting offering therapeutic intervention and special programming in a controlled environment which also offers a degree of security, supervision and 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, boarding houses or other facilities that provide primarily a supportive environment, 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.

RESPIRE 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.

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.

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.

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.

SPOUSE.....means the person to whom you are lawfully married under state law, as evidenced by a valid marriage certificate issued by any state, or in states recognizing common-law marriage, a court’s declaration of marriage or other formal document from a governmental agency evidencing proof of the marriage that is acceptable to the Plan Administrator. The term “spouse” does not include individuals who have entered into a registered Domestic Partnership, civil union, or other similar formal relationship recognized under state law that is not denominated as a marriage under the laws of that state.

SUBSTANCE USE DISORDER.....means the uncontrollable or excessive abuse of addictive substances consisting of alcohol, morphine, cocaine, heroin, opium, cannabis, and other barbiturates, amphetamines, tranquilizers and/or hallucinogens, and the resultant physiological and/or psychological dependency which develops with continued use of such addictive substances requiring Medical Care as determined by a Behavioral Health Practitioner.

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

SUBSTANCE USE DISORDER TREATMENT FACILITY.....means a facility (other than a Hospital) whose primary function is the treatment of Substance Use Disorder and is licensed by the appropriate state and local

authority to provide such service. It does not include half-way houses, boarding houses or other facilities that provide primarily a supportive environment, even if counseling is provided in such facilities.

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.

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.

WAITING PERIOD.....means the period of time that must elapse following the date an individual becomes an employee of a Participating Employer before an otherwise eligible person may be enrolled and covered under the terms of the Plan. This period of time is specified in the Adoption Agreement established between the Participating Employer and the Plan Administrator.

References in this Summary Plan Description are made to the Affordable Care Act of 2010 as amended and the associated rules relating to the Act. Reference in this booklet may also be to “ACA” which is an abbreviated reference to the Affordable Care Act of 2010.

ELIGIBILITY & ENROLLMENT SECTION

This benefit booklet contains information about the Plan for persons who meet the following description of an Eligible Person. Subject to the definitions and restrictions set forth in the Definitions Section of this Plan, Eligible Person generally means an employee of the Employer and the Eligible Dependents of an employee of the Employer who meet the eligibility requirements for this health plan coverage as established in the Adoption Agreement.

ELIGIBILITY

You are eligible to participate in this Plan if you are a full-time employee of your Employer and have met your individual Employer's eligibility requirements as stated in the **ELIGIBILITY – WAITING PERIOD – PREMIUM PAYMENT INFORMATION** section of this booklet. Please contact your Employer's Human Resources Department for information about your Employer's eligibility requirements if you have questions relating to eligibility or the Plan's waiting period. Independent contractors, leased employees or employees of a professional employee organization are not eligible to participate in this Plan. Eligibility for Medicaid or receipt of Medicaid benefits will not be taken into account in determining eligibility.

Your Eligible Dependents may also participate. This Plan's coverage does not include benefits for grandchildren (unless such children are under your legal guardianship) or foster children.

An Eligible Person may not participate in this Plan as both an employee and a dependent unless he or she is both (i) an employee of one member company of The Marmon Group of companies and (ii) a dependent of an employee of a different member company of The Marmon Group of companies. Your dependents may not participate in this Plan as a dependent of more than one employee of a Participating Employer.

ENROLLMENT

Enrollment in the Plan is not automatic. An employee who is eligible to participate in the Plan must complete the enrollment process established by the Participating Employer within the time period required. Unless otherwise communicated in writing to employees by a Participating Employer, an employee must enroll for coverage for himself / herself and eligible family members within 31 days of his or her employment date with the Participating Employer, provided he or she is eligible. Other time periods during which official enrollment in the Plan must be completed are noted under the following portions of this booklet: **“CHANGING FROM INDIVIDUAL TO FAMILY COVERAGE,” “ADDING DEPENDENTS TO FAMILY COVERAGE,” “CHANGING FROM FAMILY TO INDIVIDUAL COVERAGE,” “MID-YEAR PLAN ELECTION CHANGES,”** and **“HIPAA SPECIAL ENROLLMENTS”**.

If you do not make application for coverage within the 31 day period described above, or within the period prescribed below under “Mid-Year Plan Election Changes” or “HIPAA Special Enrollments,” as applicable, you can make application for coverage during the annual Enrollment Period determined by your Participating Employer. Such enrollment changes would be effective on a date determined by your Participating Employer. Please contact your Employer's Human Resources Department for more information.

By enrolling and/or accepting these benefits under this Plan, you agree to the reimbursement/subrogation provisions of the Plan.

MEDICARE ELIGIBLE COVERED PERSONS

If you meet the eligibility definition of an Eligible Person as stated in the this **“ELIGIBILITY & ENROLLMENT”** section and you are eligible for Medicare, please refer to the **“MEDICARE ELIGIBLE COVERED PERSONS”** section of the this booklet.

Note: In order to assist your Employer in complying with the rules that apply to employees and/or their Eligible Dependents who qualify for Medicare, it is very important that you promptly and accurately complete any requests for information from the Claim Administrator and/or your Employer.

YOUR ID CARD

You will be provided 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. When your eligibility and enrollment requirements are met, your coverage begins on the date established in the Adoption Agreement associated with your Employer. However, coverage will not begin unless you are actively at work, unless you are absent from work due to a health-related reason. (Employees who are otherwise eligible to begin coverage but are absent from work due to a health-related reason will be treated as being actively at work for purposes of commencement of coverage.)

FAMILY COVERAGE

Child(ren) used hereafter, means a natural child(ren), a stepchild(ren), an adopted child(ren) who is in your custody under an interim court order of adoption or who is placed with you for adoption and vesting you with temporary care. If the covered child(ren) is/are eligible military personnel, the limiting age is 30 years of age as described under this FAMILY COVERAGE provision in the ELIGIBILITY& ENROLLMENT SECTION of this benefit booklet.

If you have Family Coverage, your health care expenses and those of your enrolled Spouse and your (or your Spouse's) enrolled children who are under age 26 will be covered. The coverage for children will end on the birthday.

Any newborn children will be covered from the moment of birth. **Please notify your Employer's plan enrollment coordinator (typically the Human Resources Department) 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 handicapped 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 and vesting you with temporary care will be covered.

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

LIMITING AGE AND CHILDREN WITH DISABILITIES

If you have Family Coverage, your health care expenses and those of your enrolled Eligible Dependents will be covered. Eligible Dependents include enrolled children who are under age 26. The coverage for children, either married or unmarried, will end on the date they reach the limiting age as described in the foregoing sentences. This coverage, by its operation, means the Plan also complies with the provisions of Michelle's Law.

A dependent child who is enrolled in the Plan and is unable to care for him or herself due to a physical or mental disability existing on the date coverage would otherwise end due to limiting age and persisting thereafter may continue coverage regardless of age, provided the disability and inability to care for him or herself continues and provided the child continues to qualify as an Eligible Dependent in all other respects. In order to continue such coverage, you must notify the Plan and provide proof of the disability, and the child's inability to care for himself/herself, within 31 days of the date coverage would otherwise end. The Plan may require you at any time to obtain a Physician's statement certifying or re-certifying the physical or mental handicap and the child's inability to care for himself/herself.

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

You may be able to change from Individual to Family Coverage or add additional Eligible Dependents to your existing Family Coverage by means of a mid-year election change, as described below under “**MID-YEAR PLAN ELECTION CHANGES**” or “**HIPAA SPECIAL ENROLLMENTS**.”

If you do not make application to add additional dependents to your Family Coverage within the period prescribed under “**MID-YEAR PLAN ELECTION CHANGES**” or “**HIPAA SPECIAL ENROLLMENTS**” below, as applicable, you can make application for this coverage during the annual Enrollment Period determined by your Participating Employer. Such enrollment changes would be effective on a date determined by your Employer. Please contact your Employer’s Human Resources Department for more information.

CHANGING FROM FAMILY TO INDIVIDUAL COVERAGE

Should you wish to change from Family to Individual Coverage, you may be able to do so by means of a mid-year election change, as described below under “Mid-Year Plan Election Changes.” In the alternative, you can make application to change your coverage during the annual Enrollment Period determined by your Employer. Any such enrollment change, and premium adjustment, would be effective on a date determined by your Participating Employer. Please contact your Employer’s Human Resources Department for more information.

MID-YEAR PLAN ELECTION CHANGES (E.g., Changing from Individual to Family Coverage, Adding Dependents to Family Coverage; Changing from Family to Individual Coverage)

Depending on the terms of your Employer’s Section 125 plan, you may be allowed to change your enrollment elections in the middle of a Plan Year if you have a qualifying change in status. The election change must be consistent with the change in status. You should check with your Employer for details.

Changes in status that may, under the terms of your Employer’s Section 125 plan, allow you to change your elections include the following:

- Marriage.
- 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:

- Legal separation, divorce, cessation of dependent status, death of an employee, termination of employment, or reduction in the number of hours of employment;
- 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;

- Reaching a lifetime limit on all benefits in another group health plan;
 - Another group health plan no longer offering any benefits to the class of similarly situated individuals that includes you or your dependent;
 - When Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility; or
 - 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.

You may make a prospective election change that is on account of and corresponds with a change made under an employer plan (including a plan of the Participating Employer or a plan of the Spouse's employer), so long as (a) the other cafeteria plan or qualified benefits plan permits its participants to make an election change that would be permitted under applicable IRS regulations; or (b) the plan permits you to make an election for a period of coverage that is different from the period of coverage under the other cafeteria plan or qualified benefits plan. For example, if your Spouse's open enrollment period is different from the open enrollment period under the Plan, and an election is made by your Spouse during his or her employer's open enrollment to take coverage, you may modify your coverage to drop your Spouse from your coverage or you could drop coverage under the Plan entirely. The Plan Administrator, in its sole discretion and on a uniform and consistent basis, will decide whether a requested change is on account of and corresponds with a change made under the other employer plan, in accordance with prevailing IRS guidance.

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.
- 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.

“CHIPRA” Special Enrollment Opportunity

The Children’s Health Insurance Program Reauthorization Act of 2009 (CHIPRA) establishes additional special enrollment opportunities when: (1) the Eligible Person (employee) or Eligible Dependent’s Medicaid or CHIP (Children’s Health Insurance Program) coverage is terminated as a result of loss of eligibility; or the eligible individual becomes eligible for a premium assistance subsidy under Medicaid or CHIP.

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 will have to wait until your Employer’s annual open Enrollment Period 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.

HIPAA SPECIAL ENROLLMENT

If you and any of your Spouse or other Eligible Dependents did not enroll in the Plan within 31 days of becoming eligible, you may subsequently be eligible to elect coverage prior to your Employer’s next open Enrollment Period to the extent provided below.

New Spouse or Dependent. If, after you were initially eligible to enroll in the Plan, you marry a Spouse or a dependent is born to you, legally adopted by you or placed for adoption with you (such as where the child is in your custody under an interim court order of adoption or an order placing the child with you for adoption and vesting you with temporary care), your Spouse and your dependents shall be entitled to enroll in the Plan if the requirements set forth below are satisfied:

- the new Spouse or dependent is otherwise eligible for coverage under the Plan; and
- you make application to enroll the new Spouse or dependent(s) within 31 days after such marriage, birth, adoption or placement for adoption.

In the case of your marriage, if the above requirements are satisfied, coverage will begin no later than the first day of the first calendar month beginning after the date your application for enrollment is received. In the case of birth, adoption or placement for adoption, coverage will begin as of the date of birth or adoption or placement for adoption, provided the above requirements are satisfied.

Loss of Other Coverage. If you declined enrollment for yourself or your Spouse and/or other Eligible Dependents because you had other health insurance coverage, you, your Spouse and/or your other Eligible Dependents may be entitled to enroll in the Plan if the requirements set forth below are satisfied:

- you and/or your Spouse or other Eligible Dependents were covered under the group health plan of another employer or had other health insurance coverage at the time you or they were previously offered enrollment under the Plan, and declined Plan coverage;
- you and your Spouse and/or other Eligible dependents are otherwise eligible for coverage under the Plan;

- you, your Spouse and/or other Eligible Dependents, as applicable, subsequently lose eligibility for coverage as a result of:
 - legal separation, divorce, cessation of dependent status, death of an employee, termination of employment or reduction in hours;
 - any loss of eligibility for other coverage resulting from: (a) incurring a claim that would meet or exceed the lifetime limit on all benefits under that other coverage, (b) if covered under an HMO, ceasing to reside, live or work in the HMO service area, or (c) the other coverage no longer offering any benefits to a class of similarly situated individuals;
 - a current or former employer who was contributing to the cost of non-COBRA coverage for you, your Spouse and/or dependents, as applicable, ceases to make such contributions; or
 - you, your Spouse and/or dependents exhaust COBRA continuation coverage under another plan as described under ERISA Regulation Section 2590.701-2(4); and
 - you request enrollment within 31 days after your other coverage ends.

“Loss of eligibility” does not include a loss due to your failure to pay premiums when due; due to your failure to exhaust COBRA continuation coverage, if elected; voluntary election to drop the other coverage; or a fraudulent claim or misrepresentation.

Special Note Regarding Loss of Other Coverage: If you decline coverage under this Plan for yourself or your Eligible Dependents because of other health plan coverage, you may be asked to provide a written statement on a form furnished by the Plan Administrator or the Participating Employer that you are declining coverage due to the existence of other coverage. If you are asked for this written statement, then the “Loss of Other Coverage” special enrollment rights described above will be subject to a restriction. If you were asked for but did not provide the written statement requested at the time you declined Plan coverage, then, upon loss of other coverage, you and any Eligible Dependents for whom you declined coverage will not be eligible for the HIPAA Special Enrollment privileges described above.

Late Enrollments

If you or your Eligible Dependents are not enrolled within 31 days of your employment date or a later date specified in the Adoption Agreement (which has been communicated to employees of a Participating Employer) or a special enrollment date as permitted under the rules of HIPAA as noted in the HIPAA SPECIAL ENROLLMENT section of this booklet, you may enroll for coverage during the next open Enrollment Period.

Qualified Medical Child Support Order

If your Employer determines that your separated or divorced spouse or any state child support or Medicaid agency has obtained a legal qualified medical child support order (QMCSO), through a court order or an administrative process established under state law, and your current plan offers dependent coverage, you will be required to provide coverage for any child(ren) named in the QMCSO. If a QMCSO requires that you provide health coverage for your child(ren) and you do not enroll the child(ren), the Employer must enroll the child(ren) upon application from your separated/divorced spouse, the state child support agency or Medicaid agency and withhold from your pay your share of the cost of such coverage. You may not drop coverage for the child(ren) unless you submit written evidence to your Employer that the child support order is no longer in effect. The Plan may make benefit payments for the child(ren) covered by a QMCSO directly to the custodial parent or legal guardian of such child(ren), or to the party who is legally responsible for the child’s medical expenses. The Plan Administrator has adopted procedures to determine if a child support order satisfies the requirements of a QMCSO. A written copy of such procedures is available without charge upon request. Coverage will begin after the order is submitted to the Plan and determined to be a qualified order, and after the child or children have been properly enrolled under the terms of the Plan. If you are not enrolled for coverage, you will be required to enroll along with the child(ren) and your share of the cost of such coverage will be withheld from your pay.

ELIMINATION OF PREEXISTING CONDITION WAITING PERIOD

In compliance with the Patient Protection and Affordable Care Act, effective January 1, 2014 the Plan does not recognize any Pre-Existing Conditions that in prior Benefit Periods would have caused delays in coverage under the terms of the Plan. Any inadvertent references to Pre-Existing Condition Waiting Periods in this booklet should be disregarded.

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 or the Plan Administrator automatically terminates your coverage as described in this benefit booklet. It is the responsibility of the Employer or the Plan Administrator 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 or the Plan Administrator's agreement with the Claim Administrator.

Put in other words, your coverage ends on the earliest of the following: the date your employment with your Employer ends or your hours drop below any required threshold; the end of the last pay period for which a contribution was made, if you fail to pay any required premium contributions; the date you submit false claims or false information to the Plan; the date you are no longer eligible to participate in this Plan; the date this Plan terminates; or the agreement with the Claim Administrator terminates.

Coverage for your Eligible Dependents ends on the earliest of the following: the date your coverage ends; the date an Eligible Dependent no longer meets the eligibility requirements; the end of the last pay period for which a contribution was made, if you or the Eligible Dependent, as applicable, fails to pay any required premium contributions; the date false claims or false information is submitted by or for the Eligible Dependent; the date this Plan terminates; or the agreement with the Claim Administrator terminates.

Unless specifically mentioned elsewhere in this benefit booklet, if one of your Eligible Dependents becomes ineligible, his or her coverage will end as of the date the event occurs which makes him or her ineligible (for example, the date the limiting age of 26 is reached).

No benefits are available to you or your Eligible Dependents for services or supplies rendered after the date of termination of your coverage under the Healthcare 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 or the Plan Administrator's agreement with the Claim Administrator and/or termination of your coverage under the Healthcare Plan shall not affect any Claim for Covered Services rendered prior to the effective date of such termination.

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

CIRCUMSTANCES THAT MAY AFFECT BENEFITS

Your benefits (and the benefits of your eligible family members) will cease when your participation in the Plan ceases. See “**TERMINATION OF COVERAGE**,” above. Your benefits will also cease upon termination of the Plan. Other circumstances can result in the termination, reduction or denial of benefits. You should consult the “**BENEFIT HIGHLIGHTS**,” and related sections of this benefit booklet for more information.

REINSTATEMENT OF COVERAGE

If you terminate employment for any reason and are rehired within 60 days, coverage may be reinstated on the first day of the month following rehire, if the enrollment requirements are completed within 31 days. All accumulated annual and lifetime maximums that applied prior to your termination will continue to apply.

SPECIAL SITUATIONS -- EXTENSION OF COVERAGE

FAMILY AND MEDICAL LEAVE ACT OF 1993 (FMLA)

If you qualify for an approved family or medical leave of absence (as defined in the Family Medical Leave Act of 1993), eligibility may continue for the duration of the leave if you pay any required contributions toward the cost of the coverage. If your leave of absence is a paid leave, your same contributions will continue to be deducted from your pay. If your leave of absence is not a paid leave, you must pay the contributions to your Employer or you may revoke coverage during your leave. Your Employer has the responsibility to provide you with prior written notice of the terms and conditions under which payment must be made. Failure to make payment within 30 days of the due date established by your Employer will result in the termination of coverage. Subject to certain exceptions, if you fail to return to work after the leave of absence, your Employer has the right to recover from you any contributions toward the cost of coverage made on your behalf during the leave, as outlined in the FMLA. Coverage continued under this provision is in addition to coverage continued under COBRA.

If coverage is terminated for failure to make payments while you are on an approved family or medical leave of absence (as defined in the Family Medical Leave Act of 1993), coverage for you and your Eligible Dependents will be automatically reinstated on the same terms as before on the date you return to active employment if you and your Eligible Dependents are otherwise eligible under the Plan (subject to any changes in plan benefit levels that occurred during the FMLA leave.)

UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT (USERRA)

If you were covered under this Plan immediately prior to being called to active duty by any of the armed forces of the United States of America, coverage may continue for up to 24 months (18 months if your election for USERRA coverage was made before December 10, 2004) or the period of uniformed service leave, whichever is shorter, provided the leave qualifies as eligible leave under USERRA and provided you pay any required contributions toward the cost of the coverage during the leave. If the leave lasts for 30 days or less, your contribution rate will be the same as for active employees. If the leave is longer than 30 days, the required contribution will not exceed 102% of the cost of coverage. Coverage continued under this provision runs concurrently with coverage continued under COBRA.

Whether or not you elect continuation coverage under USERRA, coverage will be reinstated on the first day you return to active employment with your Employer if you comply with the requirements of USERRA for reinstatement, including returning to employment within the time framework imposed by USERRA, giving the required advance notice to your Employer and other conditions. Contact your local veterans agency for specifics or go to the Department of Labor (DOL) website for more information at www.dol.gov/dol/compliance/comp-userra.htm.

When coverage under this Plan is reinstated in accordance with USERRA, all provisions and limitations of this Plan will apply to the extent that they would have applied if you had not taken military leave and your coverage had been continuous under this Plan. The eligibility waiting period will be waived as if you had been continuously covered under this Plan from your original effective date. (This waiver of limitations does not apply to or provide coverage for any illness or injury caused or aggravated by your military service, as determined by the Veterans Administration. For complete information regarding your rights under USERRA, contact your local veterans agency.)

MEDICARE ELIGIBLE COVERED PERSONS

If you meet the definition of an Eligible Person stated in the “**ELIGIBILITY & ENROLLMENT**” section of this benefit booklet, and you are eligible for Medicare and your Medicare benefits are primary to the Plan by operation of law, this section of this benefit booklet is important for you to read and understand. This section will apply to you and to your Spouse (if your Spouse is also eligible for Medicare and his or her Medicare benefits are primary to the Plan) and, in some cases, dependent children.

Whether your Medicare benefits are primary to the Plan depends on federal law. 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.

Note: With certain exceptions, for participants in the Plan who do not have “current employment status” who elect COBRA under this Plan AND who elect coverage under Medicare, Medicare will be primary to the Plan. It is IMPORTANT to note that in such an instance or situation the Plan will not make up the difference for the benefit you would have received from Medicare if you elect COBRA but fail to enroll in Medicare Parts A and B. For this reason, if you elect COBRA and are Medicare-eligible, you must also enroll in Medicare Parts A and B in order to receive the maximum coverage for your medical expenses.

PLEASE NOTE: See your Employer or group administrator should you have any questions regarding the ESRD primary period or other provisions of the MSP regulations and their application to you, your Spouse or any other Eligible 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.

SPECIAL ELECTION FOR EMPLOYEES AND SPOUSES AGE 65 AND OVER

If you remain actively employed after reaching age 65, you or your Spouse may choose to remain covered under this Plan without reduction for Medicare benefits or designate Medicare as the primary payer of benefits. If you choose to remain covered under this Plan, this Plan will be the primary payer of benefits and Medicare will be secondary. If you choose Medicare as primary, coverage under this Plan will end. If you do not specifically choose one of the options, this Plan will continue to be primary.

If you are under age 65 and your Spouse is over age 65, still working for an employer and a participant in this Plan, he or she can make his or her own choice whether Medicare or this Plan will be primary. If he or she does not make an affirmative choice, this Plan will automatically be primary.

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 Healthcare Plan. The Utilization Review Program requires a review of the following Covered Services **before** such services are rendered:

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

You are responsible for satisfying Preadmission/Admission Review requirements. This means that you must ensure that you, your family member, or Provider of services must comply with the guidelines below. Failure to obtain Preadmission/Admission Review for services will require additional steps and/or benefit reductions as described in the provision entitled FAILURE TO NOTIFY. The toll-free telephone number for Preadmission/Admission Review is on your ID card. Please read the provisions below very carefully.

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 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 Plan.

In the event of an emergency admission, in order to receive maximum benefits under this benefit booklet and the Plan, 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 Plan.

In the event of a maternity admission, in order to receive maximum benefits under this benefit booklet and the Plan, 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 Plan.

Whenever an admission to a Skilled Nursing Facility is recommended by your Physician, in order to receive maximum benefits under this benefit booklet and the Plan, 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 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 and the Plan, 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 Plan.

Whenever Private Duty Nursing Service is recommended by your Physician, in order to receive maximum benefits under this benefit booklet and the Plan, 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.

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 Healthcare 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 Healthcare 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 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 and Summary Plan Description.

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 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, the Plan Sponsor, the Plan Administrator or the Employer will not be responsible for any related Hospital or other health care service charge incurred.

Remember that the Healthcare 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 authorize payment for the hospitalization, services or supplies unless the Claim Administrator determines it to be Medically Necessary and a Covered Service under the Healthcare 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 Healthcare Plan may limit or exclude that service. In that case, the Medically Necessary determination does not override the benefit provision in this 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 sent by the Claims Administrator.

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
Health Care Service Corporation
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, Plan Sponsor, Plan Administrator or the Employer 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 potential benefits provided under this benefit booklet and the Healthcare Plan.

Should you fail to notify the Claim Administrator as required in the Preadmission Review provision of this section, you will then be responsible for the first 30% up to \$5,000 per admission of the Hospital or facility charges for an eligible stay or 30% up to \$5,000 per admission of the charges for eligible Covered Services for Private Duty Nursing in addition to any deductibles, Copayments and/or Coinsurance applicable to this benefit booklet and the Plan. However, this benefit reduction will not apply to Private Duty Nursing Services, Skilled Nursing Facilities service or Coordinated Home Care Program. This amount of benefit reduction for failure to notify shall not be eligible for later consideration as an unreimbursed expense under any Benefit Section of this benefit booklet or the Plan, nor can it be applied to your out-of-pocket expense limit, if applicable, as described in 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 Healthcare Plan.

CLAIM ADMINISTRATOR'S MENTAL HEALTH UNIT

The Claim Administrator's Mental Health Unit has been established to perform preadmission review and length of stay review for your Inpatient Hospital services for the treatment of Mental Illness and Substance Use Disorder. The Mental Health Unit is staffed primarily by Physicians, Psychologists, and registered nurses.

Failure to contact the Mental Health Unit or to comply with the determinations of the Mental Health Unit may result in a reduction of benefits. The Mental 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.

You are responsible for satisfying Preauthorization requirements. This means that you must ensure that you, your family member, your Behavioral Health Practitioner or Provider of services must comply with the guidelines below. Failure to Preauthorize services will require additional steps and/or benefit reductions as described in the provision entitled FAILURE TO PREAUTHORIZE OR NOTIFY.

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 Plan.

In order to receive maximum benefits under this Healthcare Plan, you must Preauthorize your nonemergency Inpatient Hospital admission for the treatment of Mental Illness or Substance Use Disorder by calling the Mental Health Unit. Participating and Non-Participating Providers may contact the Mental Health unit on your behalf to Preauthorize services for you, when required, but it is your responsibility to ensure Preauthorization requirements are satisfied. This call must be made at least three business days 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 Plan.

In order to receive maximum benefits under this Healthcare Plan, you or someone who calls on your behalf must notify the Mental Health Unit no later than two business days or as soon as reasonably possible after the admission for the treatment of Mental Illness or Substance Use Disorder has occurred. If the call is made any later than the specified time period, you will not be eligible for maximum benefits. Participating and Non-Participating Providers may contact the Mental Health unit on your behalf to Preauthorize services for you, when required, but it is your responsibility to ensure Preauthorization requirements are satisfied.

❖ 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 Plan.

In order to receive maximum benefits under this Healthcare Plan, you must notify the Mental Health Unit no later than 48 hours after the admission for the treatment of Mental Illness or Substance Use Disorder has occurred. Participating and Non-Participating Providers may contact the Mental Health unit on your behalf for you, when required, but it is your responsibility to ensure these requirements are satisfied. This call must be made at least 48 hours after the admission for the treatment of Mental Illness or Substance Use Disorder has occurred. The Mental 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 Healthcare Plan, an additional call must be made to the Mental 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 Plan.

Upon completion of the Preauthorization or Emergency Mental Illness or Substance Use Disorder Review, the Mental Health Unit will send you a letter confirming that you or your representative called the Mental 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 Mental 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 Mental Health Unit Physician for review.

MEDICALLY NECESSARY DETERMINATION

The decision that Inpatient Hospital admission 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 Mental Health Unit. If the Mental Health Unit Physician concurs that the Inpatient Hospital admission, Outpatient service, or other health care service or supply does not meet the criteria for Medically Necessary care, 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 determination, 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 Mental 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 Mental 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 Mental Health Unit's determination of Medically Necessary care is limited to merely whether a proposed admission, continued hospitalization or other health care service is Medically Necessary under the terms of the Plan.

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

Remember that your Healthcare 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 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 Mental Health Unit Physician decides they were not Medically Necessary.

MENTAL HEALTH UNIT PROCEDURE

When you contact the Mental Health Unit to Preauthorize your Inpatient Hospital admission 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 Mental Health Unit to Preauthorize your Inpatient Hospital admission 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 Mental 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 Mental Health Unit prior to or while receiving services, you or the Behavioral Health Practitioner may appeal that determination by contacting the Mental Health Unit and requesting an expedited appeal. The Mental 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 Mental 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 disagrees with the Mental 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 Mental 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, the Plan Sponsor, the Plan Administrator or the Employer, 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 Mental Health Unit will not interfere with your relationship with any Behavioral Health Practitioner. However, the Mental Health Unit has been established for the specific purpose of assisting you in maximizing your benefits as described in this benefit booklet.

Should you fail to Preauthorize or notify the Mental Health Unit as required in the Preauthorization Review provision of this section, you will then be responsible for the first 30% up to \$5,000 per admission of the Hospital charges for an eligible Hospital stay in addition to any deductibles, Copayments and/or Coinsurance applicable to this benefit booklet and the Plan. This amount of benefit reduction shall not be eligible for later consideration as an unreimbursed expense under any Benefit Section of this benefit booklet or the Plan, nor can it be applied to your out-of-pocket expense limit, if applicable to this benefit booklet or the Plan.

INDIVIDUAL BENEFITS MANAGEMENT PROGRAM (“IBMP”)

In addition to the benefits described in this benefit booklet, if your condition would otherwise require continued care in a Hospital or other health care facility, provision of alternative benefits for services rendered by a Participating Provider in accordance with an alternative treatment plan may be available to you.

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 Healthcare 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 or exclusions of the Healthcare Plan.

MEDICARE ELIGIBLE MEMBERS

The provisions of the CLAIM ADMINISTRATOR’S MENTAL HEALTH UNIT section do not apply to you if you are Medicare Eligible and have secondary coverage provided under the Healthcare Plan.

THE PARTICIPATING PROVIDER OPTION

The Healthcare Plan utilizes 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 Web site 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 potential 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 benefit Plan's coverage, your first Benefit Period begins on your Coverage Date, and ends on the first December 31st following that date.

YOUR DEDUCTIBLE

If you have Individual Coverage, each Benefit Period you must satisfy a **\$1,500** benefit program deductible for Covered Services rendered by Participating Provider(s) and a separate **\$1,500** deductible for Covered Services rendered by Non-Participating Provider(s) or Non-Administrator Provider(s) before receiving benefits. After you have Claims for Covered Services in a Benefit Period which exceed this deductible amount, your benefits will begin.

FAMILY DEDUCTIBLE

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

The deductible amount may be adjusted based on the cost-of-living adjustment determined under the Internal Revenue Code and rounded to the nearest \$50.

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.

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 (up to any limits imposed by the Plan) when you receive them as an Inpatient in a Hospital and they otherwise satisfy the terms and conditions of Covered Services under the Plan.

Inpatient Covered Services

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

Preadmission Testing

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

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

Partial Hospitalization Treatment

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

Coordinated Home Care

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

You are entitled to benefits for 100 visits in a Coordinated Home Care Program per Benefit Period.

BENEFIT PAYMENT FOR INPATIENT HOSPITAL COVERED SERVICES

Participating Provider

Subject to all of the terms and conditions of the Plan, 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. [Refer to the definition of Eligible Charge in the Definitions Section of this booklet for more information.]

Non-Participating Provider

Subject to all of the terms and conditions of the Plan, 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. [Refer to the definition of Eligible Charge in the Definitions Section of this booklet for more information.]

Benefits for services under a Coordinated Home Care Program of a Non-Participating Provider will be provided at 100% of the Eligible Charge after you have met your program deductible.

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.

In order for you to continue to receive benefits at the Participating Provider payment level following an emergency admission to a Non-Participating Provider Hospital or Non-Administrator Provider Hospital, you must transfer to a Participating Provider Hospital as soon as you are no longer in need of immediate medical attention for a medical condition with respect to which the absence of such immediate medical attention would likely result in serious and permanent medical consequences.

OUTPATIENT HOSPITAL CARE

The following are Covered Services (subject to all of the terms and conditions of the Plan) 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
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—treatment must occur within 72 hours of the accident or as soon as reasonably possible.

8. Emergency Medical Care
9. Mammograms
10. Pap Smear Test—Benefits will be provided for an annual routine cervical smear or Pap smear test for females.
11. Prostate Test and Digital Rectal Examination—Benefits will be provided for an annual routine prostate-specific antigen test and digital rectal examination for males.
12. Ovarian Cancer Screening—Benefits will be provided for annual ovarian cancer screening for females using CA-125 serum tumor marker testing, transvaginal ultrasound, and pelvic examination.
13. Colorectal Cancer Screening—Benefits will be provided for colorectal cancer screening as prescribed by a Physician, in accordance with the published American Cancer Society guidelines on colorectal cancer screening or other existing colorectal cancer screening guidelines issued by nationally recognized professional medical societies or federal government agencies, including the National Cancer Institute, the Centers for Disease Control and Prevention, and the American College of Gastroenterology.
14. Bone Mass Measurement and Osteoporosis—Benefits will be provided for bone mass measurement and the diagnosis and treatment of osteoporosis.

BENEFIT PAYMENT FOR OUTPATIENT HOSPITAL COVERED SERVICES

Participating Provider

Subject to all of the terms and conditions of the Plan, 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

Subject to all of the terms and conditions of the Plan, 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

Subject to all of the terms and conditions of the Plan, including the program deductible, 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

Subject to all of the terms and conditions of the Plan, benefits for Emergency Accident Care will be provided at **90%** of the Eligible Charge when you receive Covered Services from either a Participating, Non-Participating or Non-Administrator Provider.

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

Benefits for Emergency Medical Care will be provided at **90%** of the Eligible Charge when you receive Covered Services from either a Participating, Non-Participating or Non-Administrator Provider.

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

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

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.

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. **Pre-approval by the Claim Administrator for services to be obtained under this Plan provision is required and the Provider may balance bill you for any of its charges for its services that exceed the Eligible Charge.**

IMPORTANT REMINDER

In order for you to receive benefits at the Participating Provider payment level following an emergency admission to a Non-Participating Provider Hospital or Non-Administrator Provider Hospital, you must transfer to a Participating Provider Hospital as soon as you are no longer in need of immediate medical attention for a medical condition with respect to which the absence of such immediate medical attention would likely result in serious and permanent medical consequences.

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 of the Plan 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

Subject to all of the terms and conditions of the Plan, 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 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;
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) the patient is a child who 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.

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 and such assistance meets the standards followed by the Claims Administrator relating to medical necessity and/or accepted practice. 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 elective).
4. Surgical treatment of morbid obesity — Benefits will be limited to a lifetime maximum of one procedure.

Additional Surgical Opinion

You coverage includes benefits for an additional surgical opinion following a recommendation for elective Surgery. Your benefits will be limited to one consultation and related Diagnosis Service by a Physician. If you request, benefits will be provided for an additional consultation when the need for Surgery, in your opinion, is not resolved by the first arranged consultation.

Medical Care

Subject to all of the terms and conditions of the Plan, 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
2. You are a patient in a Partial Hospitalization Treatment Program or Coordinated Home Care Program; or
3. You visit your Physician's office or your Physician comes to your home.

Consultations

Your coverage includes benefits for consultations when you are an Inpatient in a Hospital or Skilled Nursing Facility. The consultation must be requested by your 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 be provided if these services are rendered by a Physician, or duly certified, registered or licensed health care professionals with expertise in diabetes management. Benefits for such health care professionals will be provided in accordance with 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—Treatment must occur within 72 hours of the accident or as soon as reasonably possible.

Emergency Medical Care

Well Child Care

Benefits will be provided for Covered Services provided by a Physician to children under age 19, even though they are not ill. Please note, benefits for Well Child Care **will not** be provided when received from a Non-Participating Provider or a Non-Administrator Provider.

Benefits will be limited to the following services, unless otherwise required to comply with the Affordable Care Act:

1. Routine diagnostic medical procedures;
2. Physical examinations will be limited to the following schedule;
 - a. Birth to age 1: six visits
 - b. Age 1-2: three visits
 - c. Age 3-6: four visits
 - d. Age 7-18: five visits
3. Routine diagnostic tests.

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 registered professional Physical Therapist under the supervision of a Physician. 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.

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

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.

Mammograms

Pap Smear Test—Benefits will be provided for an annual routine cervical smear or Pap smear test for females.

Prostate Test and Digital Rectal Examination—Benefits will be provided for an annual routine prostate-specific antigen test and digital rectal examination for males.

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

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

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. However, benefits will not be provided for foot orthotics defined as any in-shoe device designed to support the structural components of the foot during weight-bearing activities.

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 will be provided for therapeutic abortions as noted in the “OTHER COVERED SERVICES” section of this benefit booklet.

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

Leg, Back, Arm and Neck Braces

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).

Colorectal Cancer Screening—Benefits will be provided for colorectal cancer screening as prescribed by a Physician, in accordance with the published American Cancer Society guidelines on colorectal cancer screening or other existing colorectal cancer screening guidelines issued by nationally recognized professional medical societies or federal government agencies, including the National Cancer Institute, the Centers for Disease Control and Prevention, and the American College of Gastroenterology.

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

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

BENEFIT PAYMENT FOR PHYSICIAN SERVICES

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

Participating Provider

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

Benefits for chiropractic and osteopathic manipulation will be provided at **50%** of the Maximum Allowance, when Covered Services are received from a Participating Provider.

Benefits for chiropractic and osteopathic manipulation from a Participating Provider will be subject to the program deductible.

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. No benefits will be provided for chiropractic and osteopathic manipulations received from a Non-Participating Provider.

Emergency Care

Benefits for Emergency Accident Care will be provided at **90%** of the Maximum Allowance when rendered by either a Participating or Non-Participating Provider after you have met your Participating Provider program deductible.

Benefits for Emergency Medical Care will be provided at **90%** of the Maximum Allowance when rendered by either a Participating or Non-Participating Provider after you have met your program deductible. However, Emergency Medical Care Covered Services for the examination and testing of a victim of criminal sexual assault or abuse to determine whether sexual contact occurred, and to establish the presence or absence of sexually transmitted disease

or infection, will be paid at 100% of the Maximum Allowance whether or not you have met your program deductible.

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 Surgical Assistants

- Retail Health Clinics
- Speech Therapists

Other approved Professional Providers than those listed above may 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, if you receive Covered Services from Participating Providers, 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 Surgical Assistants
- Retail Health Clinics

- Speech Therapists

Other approved Professional Providers, in addition to those listed above, have not signed an agreement with the Claim Administrator to accept the Maximum Allowance as payment in full. Therefore, if you receive Covered Services from Non-Participating Providers, you are responsible to those Providers for the difference between the Claim Administrator's benefit payment which is based on the Eligible Charge for the service and such Provider's charge to you. [Refer to the definition of Eligible Charge and Maximum Allowance in the Definitions Section of this booklet for more information.]

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

KNOW WHAT BENEFITS YOU MAY EXPECT FROM THE PLAN

LIMITED BENEFITS WILL BE PAID WHEN NON-PARTICIPATING PROVIDERS AND/OR NON-ADMINISTRATOR PROVIDERS ARE UTILIZED FOR SERVICES. FOR MORE INFORMATION, REFER TO THE BEGINNING PAGES OF THIS BOOKLET

OTHER COVERED SERVICES

This section of your benefit booklet describes “Other Covered Services” and the benefits that will be provided for them. Subject to the terms and conditions of the Plan, benefits for the following will be paid in accordance with “Benefit Payment For Other Covered Services”.

- 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
- Jobst garments—Benefits will be provided for jobst garments and will be limited to a maximum of 2 pairs per Benefit Period.
- Wigs—Benefits will be provided for wigs (also known as cranial prostheses) when your hair loss is due to Chemotherapy, radiation therapy, or Crohn’s disease. Benefits for wigs will be limited to a lifetime maximum of two.
- Foot orthotics (for example, custom-molded shoe inserts).
- Termination of Pregnancy—Benefits will be provided for termination of pregnancy by surgical or prescription drug (mifepristone, also known as RU-486) procedures for an employee or Spouse only, when the life of the mother would be endangered if the fetus were to come to term.
- Reduction of multiple pregnancy—Benefits will be provided for selective or non-selective reduction of multiple pregnancy for an employee or Spouse only, provided every effort is taken to ensure the health of the remaining fetus(es) when; a) one (or more) fetus is abnormal, b) the mother’s health is in danger, or c) there are three or more fetuses and they are likely to be spontaneously aborted or delivered prematurely with a high risk of either dying or being harmed.
- Optometrist—Benefits will be provided for Optometric services which may be legally rendered by an Optometrist provided that benefits would have been provided had such services been rendered by a Physician.
- Cochlear Implants—Benefits will be provided for unilateral or bilateral cochlear implants (CI) and associated aural rehabilitation deemed medically necessary if the patient meets **ALL** the following selection criteria:

- A) One year or older with severe to profound pre or post lingual sensorineural hearing loss (defined as a hearing threshold of 70 decibels [dB] or above); AND
- B) Limited benefit from hearing aids; AND
- C) Cognitive ability to use auditory clues and a willingness to undergo an extended program of rehabilitation; AND
- D) No contraindications to surgery (i.e., infection, cranial nerve cannot be stimulated); AND
- E) The device is used in accordance with U.S. Food and Drug Administration (FDA) approved labeling.

BENEFIT PAYMENT FOR OTHER COVERED SERVICES

Subject to the terms and conditions of the Plan **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 if those services are received from a Participating Provider.

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.

Benefits for Ambulance Transportation received from a Participating or Non-Participating Provider will be provided at 100% of the Maximum Allowance or 100% of the Eligible Charge, but subject to the program deductible.

The expenses that are your responsibility for your Other Covered Services will depend on whether you receive services from a Participating Provider or Non-Participating Provider.

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 Surgical Assistants
- Retail Health Clinics
- Speech Therapists

Other approved Professional Providers than those listed above may 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, if you receive Covered Services from Participating Providers, 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
- Orthotic Providers
- Physical Therapists
- Prosthetic Providers
- Registered Surgical Assistants
- Retail Health Clinics
- Speech Therapists

Other approved Professional Providers, in addition to those listed above, have not signed an agreement with the Claim Administrator to accept the Maximum Allowance as payment in full. Therefore, if you receive Covered Services from Non-Participating Providers, you are responsible to those Providers for the difference between the Claim Administrator's benefit payment which is based on the Eligible Charge for the service and such Provider's charge to you. [Refer to the definition of Eligible Charge and Maximum Allowance in the Definitions Section of this booklet for more information.]

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

KNOW WHAT BENEFITS YOU MAY EXPECT FROM THE PLAN

LIMITED BENEFITS WILL BE PAID WHEN NON-PARTICIPATING PROVIDERS AND/OR NON-ADMINISTRATOR PROVIDERS ARE UTILIZED FOR SERVICES. FOR MORE INFORMATION, REFER TO THE BEGINNING PAGES OF THIS BOOKLET

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: a) human organ transplants; b) cardiac rehabilitation services; or c) preventive care services.

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 a transplant procedure, no coverage is available to you under the Plan unless the recipient of the transplant is covered by this Plan and services are rendered through the Claim Administrator Approved Human Organ Transplant Program.

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 an appropriate accreditation for such procedures.**
- If you are the recipient of the transplant, benefits will be provided for transportation and lodging for you and a companion. If the recipient of the transplant is a dependent child under the limiting age of this benefit booklet, benefits for transportation and lodging will be provided for the transplant recipient and two companions. For benefits to be available, your place of residency must be more than 50 miles from the Hospital where the transplant will be performed.
- Benefits for transportation and lodging are available only if the services are being rendered through the Claims Administrator Approved Human Organ Transplant Program and limited to a combined maximum of \$10,000 per transplant. The maximum amount that will be provided for lodging is \$50 per person per day.

SPECIAL NOTE – ORGAN TRANSPLANT RELATED BENEFIT EXCLUSIONS

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

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

CARDIAC REHABILITATION SERVICES

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

PREVENTATIVE CARE SERVICES

Benefits will be provided for the following Covered Services and will not be subject to any deductible, Coinsurance, Copayment or maximum when such services are received from a Participating Provider:

- evidence-based items or services that have in effect a rating of “A” or “B” in the current recommendations of the United States Preventive Services Task Force (“USPSTF”);
- immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (“CDC”) with respect to the individual involved;
- evidenced-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (“HRSA”) for infants, children, and adolescents;
- with respect to women, such additional preventive care and screenings, not described above, as provided for in comprehensive guidelines supported by the HRSA.
- birth control options for females covered under the Plan (including oral contraceptive pills, intrauterine devices and contraceptive patches) are included as Covered Services at no cost to the Eligible Person, in compliance with the Affordable Care Act.

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

The preventive care services described above may change as USPSTF, CDC and HRSA guidelines are modified. For more information, you may access the website at www.bcbsil.com or contact customer service at the toll-free number on your identification card.

Examples of Covered Services included are routine annual physicals, immunizations, well child(ren) care, cancer screenings, mammograms, bone density tests, screenings for prostate cancer and colorectal cancer, smoking cessation services and healthy diet counseling and obesity screenings/counseling.

Examples of covered immunizations included are Diphtheria, Haemophilus influenza type b, Hepatitis B, Measles, Mumps, Pertussis, Polio, rubella, Tetanus, Varicella and other immunization that is required by law for a child(ren). Allergy injections are not considered immunizations under this benefit provision.

No benefits will be provided for Preventive Care Services received from a Non-Participating Provider or a Non-Administrator Provider.

WELLNESS CARE

Benefits will be provided for Covered Services when rendered by a Participating Provider, even though you are not ill. Benefits will be limited to the following services unless the services are otherwise required to comply with the Affordable Care Act:

1. Routine diagnostic medical procedures;
2. Routine EKG;
3. Routine x-ray;
4. Routine ovarian cancer screening;
5. Routine colorectal cancer screening x-ray.

Participating Provider

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

Non-Participating Provider or Non-Administrator Provider

No benefits will be provided for wellness care received from either a Non-Participating Provider or a Non-Administrator 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 not be provided for Covered Services received in an Uncertified Skilled Nursing Facility.

You are entitled to benefits for 100 days of care in a Skilled Nursing Facility per Benefit Period.

AMBULATORY SURGICAL FACILITY

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

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

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

MENTAL ILLNESS SERVICES AND SUBSTANCE USE DISORDER REHABILITATION TREATMENT

Subject to all of the terms and conditions of the Plan, benefits for all of the Covered Services described in this benefit booklet are available for the diagnosis and/or treatment of Mental Illness and Substance Use Disorders. Additionally, Inpatient benefits for such Covered Services will also be provided for the diagnosis and/or treatment of Inpatient Mental Illness and /or Substance Use Disorders in a Residential Treatment Center. Benefit levels provided under the Plan will be subject to the Claims Administrator's contractual relationships, if any, with the service Providers utilized. Medical Care for the treatment of a Mental Illness is eligible when rendered by a Behavioral Health Practitioner working within the scope of their license.

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.

Benefits for Bariatric Surgery will be limited to a lifetime maximum of 1.

MATERNITY SERVICE

Subject to the terms and conditions of the Plan, 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. However, Maternity Service for dependent children will not be covered. 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).

Benefits for Maternity Services will not be provided for dependent children or non-Spouse dependent adults.

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 or the inability to sustain a successful pregnancy. The one year requirement will be waived if your Physician determines 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; or, efforts to conceive as a result of one year of medically based and supervised methods of conception, including artificial insemination, have failed and are not likely to lead to a successful pregnancy.

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.

No benefits will be provided for the treatment of infertility.

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; and
4. Prostheses and physical complications of all stages of the mastectomy including, but not limited to, lymphedemas.

MDLIVE SERVICES

A program of medical and/or behavioral telecommunications based consultations is available as of January 1, 2015 through an organization known as MDLIVE. The cost of the consultation services obtained through MDLIVE is the responsibility of the Eligible Person. The cost will be counted as part of the annual medical Out-of-Pocket expense limit for In-Network services. The fees or cost for medical consultations and/or consultations relating to behavioral matters are noted in the Highlights Section of this booklet. Access to services from MDLIVE may be obtained by contacting the MDLIVE website at www.MDLIVE.com or via the telephone by calling 1-888-632-2738.

PAYMENT PROVISIONS

Lifetime Maximum

The total dollar amount that will be available in benefits for you is unlimited subject to the separate dollar maximums for specific Covered Services described earlier in this benefit booklet.

Cumulative Benefit Maximums

All benefits payable under this benefit booklet are cumulative. Therefore, in calculating the benefit maximums payable for a particular Covered Service or in calculating the remaining balance under the Lifetime Maximums, the Claim Administrator will include benefit payments under both this and/or any prior or subsequent Claim Administrator's benefit booklet issued to you as an Eligible Person or a dependent of an Eligible Person under this Healthcare Plan.

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. The added costs associated with a failure to comply with the Plan's various preauthorization or notification requirements as established in this booklet **DO NOT** apply to the Plan's individual and family out-of-pocket maximum limits.

For Participating Providers

If you have Individual Coverage and your out-of-pocket expense (the amount remaining unpaid for Covered Services after benefits have been provided) during one Benefit Period equals **\$3,000**, any additional eligible Claims for Participating Providers (except for those charges specifically excluded below) during that Benefit Period will be paid at **100%** of the Eligible Charge or Maximum Allowance as applicable.

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

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

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

- Charges that exceed the Eligible Charge or Maximum Allowance
- The Coinsurance resulting from Covered Services rendered by a Non-Participating Provider or Non-Administrator Provider
- Charges associated with failure to comply with the Plan's preauthorization or notification requirements

If you have Family Coverage and your family's out-of-pocket expense (the amount remaining unpaid for Covered Services after benefits have been provided) equals **\$6,000** during one Benefit Period, then, for the rest of the Benefit Period, all other family members will have benefits for eligible Covered Services (except for those charges specifically excluded above) provided at 100% of the Eligible Charge or Maximum Allowance as applicable.

Benefits under Family Coverage will not be provided at the 100% payment level until the entire family out-of-pocket expense limit has been met.

For Non-Participating Providers

If you have Individual Coverage and your out-of-pocket expense (the amount remaining unpaid for Covered Services after benefits have been provided) during one Benefit Period equals \$6,000, any additional eligible Claims for Non-Participating Providers (except for those Covered Services specifically excluded below) during that Benefit Period will be paid at 100% of the Eligible Charge or Maximum Allowance as applicable.

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

- The Non-Participating Provider program deductible
- Charges for Out-Patient prescription drugs
- The payments for Covered Services rendered by a Non-Participating Provider for which you are responsible after benefits have been provided

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

- Charges that exceed the Eligible Charge or Maximum Allowance
- The Coinsurance resulting from Covered Services you may receive from a Participating Provider
- The Coinsurance resulting from Hospital services rendered by a Non-Administrator Hospital or other Non-Administrator Provider facility for Covered Services
- Charges associated with failure to comply with the Plan's preauthorization or notification requirements

If you have Family Coverage and your family's out-of-pocket expense (the amount remaining unpaid for Covered Services after benefits have been provided) equals \$12,000 during one Benefit Period, then, for the rest of the Benefit Period, all other family members will have benefits for eligible Covered Services (except for those charges specifically excluded above) provided at 100% of the Eligible Charge or Maximum Allowance as applicable. Benefits under Family Coverage will not be provided at the 100% payment level until the entire family out-of-pocket expense limit has been met.

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

EXTENSION OF BENEFITS IN CASE OF TERMINATION

If you are an Inpatient at the time your coverage under this Plan is terminated, benefits will be provided for, and limited to, the Covered Services of this Plan which are rendered by and regularly charged for by a Hospital, Skilled Nursing Facility, Substance Use Disorder Treatment Facility, a facility for the treatment of a Mental Illness disorder, Partial Hospitalization Treatment Program 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 or your Eligible Dependent will no longer benefit from standard medical care or have chosen to receive hospice care rather than standard care and have been determined to be eligible for the Program based on criteria established by the Claims Administrator or the Plan Administrator. 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;
11. Bereavement Counseling, if available.

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

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

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

Benefit Payment for Hospice Care Program Services

Benefit payment for Covered Services rendered by a Hospice Care Program Provider will be provided at the same level as described for Inpatient Hospital Services, after the program deductible has been met.

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 includes benefits for drugs and supplies which are self-administered. 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 Prescription Drug Provider. You can visit the Claim Administrator's Web site at www.bcbsil.com for a list of Participating Prescription Drug Providers. The Pharmacies that are Participating Prescription Drug providers 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 and the Healthcare Plan. 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 purposes of this Benefit Section only, the definition of Eligible Charge shall read as follows:

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

Additionally, the following definition(s) shall apply to this Benefit Section:

FORMULARY.....means a brand name drug or brand name diabetic supply that has been designated as a preferred drug or supply by the Claim Administrator.

SPECIALTY DRUGS.....means prescription drugs generally prescribed for use in limited patient populations or diseases. These drugs are typically injected or infused, but may also include high cost oral medications. In addition, patient support and/or education may be required for these drugs. The list of Specialty Drugs is subject to change. You should refer to the formulary list, contact your Pharmacy or refer to the Claim Administrator's Web site (www.bcbsil.com) to determine which drugs are Specialty Drugs.

PRIOR AUTHORIZATION REQUIREMENT

When certain medications and drug classes are prescribed for use, in order to receive maximum benefits under the terms of the Plan, you will be required to obtain authorization from the Claim Administrator. Medications included in this program are subject to change and other medications for other conditions may be added to the program. Your Physician must send a letter to the Claim Administrator's prescription drug administrator explaining the reason for the prescription. The prescription drug administrator will review the letter and determine whether the reason for the prescription meets the criteria for Medically Necessary care. You and your Physician will be notified of the prescription drug administrator's determination. You should refer to the formulary list, contact your Pharmacy or refer to the Claim Administrator's website (www.bcbsil.com) to determine which medications and drug classes require prior authorization. **No benefits will be provided for such drugs as noted in this paragraph, if prior authorization is not received.**

STEP THERAPY

When certain medications and drug classes are prescribed, your Physician will be required to obtain authorization from the Claim Administrator. Medications included in this program are subject to change and other medications for other conditions may be added to the program. Although you may currently be on therapy, your Claim may need to be reviewed to see if the criteria for coverage of further treatment has been met. A documented treatment with a generic or brand therapeutic alternative medication may be required for continued coverage of the brand name medication.

The Claim Administrator's prescription drug administrator will send a questionnaire to your Physician upon your or your Pharmacy's request. The questionnaire must be returned to the prescription drug administrator who will review the questionnaire and determine whether the reason for the prescription meets the criteria for Medically Necessary care.

To find out more about step therapy requirements or to determine which drugs or drug classes require step therapy, you should contact your Pharmacy or refer to the Formulary Drug List by accessing the Web site at www.bcbsil.com or call the Customer Service toll-free number on your identification card.

SPECIALTY DRUG PROGRAM

Benefits for prescription drugs that are listed as part of the Prime Therapeutics Specialty Drug Program will only be available under the terms of that Program through the Prime Specialty Pharmacy. Plan benefits for prescription drugs which are on the Specialty Drug listing will not be available if obtained on an Out-of-Network basis, nor will a benefit be available if they are obtained from a retail pharmacy. Dispensing levels, that is the number of days of supply, provided for any prescription drug that is part of this Program will be governed by the protocols established by the Program.

COVERED SERVICES

The drugs and supplies for which benefits are available under this Benefit Section are:

- drugs which are self-administered that require, by federal law, a written prescription;
- self-injectable insulin and insulin syringes;
- diabetic supplies, as follows: test strips, glucagon emergency kits, lancets and alcohol wipes.

Benefits for these drugs will be provided when:

1. you have been given a written prescription for them by your Physician, Dentist, Optometrist or Podiatrist; and
2. you purchase the drugs from a Pharmacy or from a Physician, Dentist, Optometrist or Podiatrist who regularly dispenses drugs, and
3. the drugs are self-administered.

Benefits will not be provided for:

- drugs used for cosmetic purposes (including but not limited to, Retin-A/Tretinoin and Minoxidil/Rogaine);
- drugs for which there is an over-the-counter product available with the same active ingredient(s);
- drugs which are not self-administered;
- drugs used to treat infertility;
- any devices or appliances except as specifically mentioned above;
- charges that you may incur for the drugs being administered to you.

NOTE: Benefits will not be provided for any refills if the prescription is more than one year old.

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 type drugs, larger quantities may be obtained through the Home Delivery Prescription Drug Program. For information on these drugs, contact your Participating Prescription Drug Provider or the Claim Administrator's office. Benefits for prescription inhalants will not be restricted on the number of days before an inhaler refill may be obtained.

Benefit Payment for Prescription Drugs

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.

Prescription drug benefits obtained under the Outpatient Prescription Drug Program will be governed by a claims protocol known as "Member Pay the Difference" which means that the benefit will be calculated based on the difference in the cost for prescriptions when a brand name drug has a generic equivalent. The member (meaning Eligible Person) will be responsible for the non-formulary brand Copayment plus the difference in cost between the non-formulary brand drug and its generic equivalent. However, if the member's doctor has a particular clinical reason for prescribing the brand drug and indicates "do not substitute" or "dispense as written" on the prescription, the cost to the member would be limited to the non-formulary brand copayment.

Benefits for certain over the counter drugs or supplements, which are prescribed for an Eligible Person, will be provided as required to comply with the Affordable Care Act at no cost share to the Eligible Person. Examples of this type of benefit coverage as of January 1, 2015 are for prescribed aspirin, Vitamin D, Folic Acid, Iron and Fluoride.

When you obtain drugs and diabetic supplies from a Participating Prescription Drug Provider, after you have met the program deductible, benefits will be provided at:

- 80% of the Eligible Charge for each prescription - for generic drugs.
- 80% of the Eligible Charge for each prescription - for Formulary brand name drugs.
- 80% of the Eligible Charge for each prescription - for non-Formulary brand name drugs.

When you obtain drugs or diabetic supplies from a non-Participating Prescription Drug Provider (other than a Participating Prescription Drug Provider), after you have met the program deductible, benefits will be provided at 75% of the amount you would have received had you obtained drugs from a Participating Prescription Drug Provider reduced by a 20% Coinsurance.

Home Delivery Prescription Drug Program

In addition to the benefits described in this Benefit Section, your coverage includes benefits for maintenance type drugs obtained through the Home Delivery Prescription Drug Program. For information about this program, contact your employer or Claim Administrator.

When you obtain drugs through the Home Delivery Prescription Drug Program, benefits will be provided at:

- 80% of the Eligible Charge for each prescription - for generic drugs.
- 80% of the Eligible Charge for each prescription - for Formulary brand name drug.
- 80% of the Eligible Charge for each prescription - for non-Formulary brand name drugs.

When you obtain diabetic supplies from a Participating Prescription Drug Provider, you must pay the Formulary brand name coinsurance level described above for each prescription. You will be responsible for the remaining Eligible Charge.

HEARING CARE PROGRAM

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

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

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

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

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

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

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

Benefit Period

Your hearing care Benefit Period begins on the first date a Covered Service is received after your Coverage Date and continues for a period of 12 consecutive months thereafter. Later Benefit Periods will begin on the first date a Covered Service is received following the expiration of your prior Benefit Period.

Covered Services

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

Audiometric Examination
Hearing Aid Evaluation
Conformity Evaluation
Hearing Aids

Benefits will be limited to one Covered Service(s) of each type listed above per Benefit Period except for Hearing Aids. Benefits for Hearing Aids will be subject to the frequency limitation of one (1) per ear every five years when due to accident, illness or congenital defects.

Special Limitations

Benefits will not be provided for the following:

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

Benefit Payment for Hearing Care

Benefits for hearing care Covered Services will be provided at 80% of the Usual and Customary Fee after the Eligible Person has met their deductible under the Healthcare Plan. Hearing exams are limited to one (1) per year.

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

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

BENEFIT FOR COCHLEAR IMPLANTS

Refer to the OTHER COVERED SERVICES section of this benefit booklet for information relating to potential benefits under the Plan for cochlear implants. Plan benefits associated with Medically Necessary cochlear implants are not considered part of the HEARING CARE PROGRAM.

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” 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 Healthcare Plan is as follows:

1. determine what the payment for a Covered Service would be following the payment provisions of this coverage.
2. deduct from the charges eligible under Medicare, the amount paid 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.)
3. the lesser of the two amounts determined in accordance with step 1 and step 2 above is the amount that will be paid under the Healthcare 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.

SECOND REMINDERS TO MEDICARE ELIGIBLE INDIVIDUALS – Who are eligible for Marmon Healthcare Plan coverage

Note: With certain exceptions, for participants in the Plan who do not have “current employment status” with an Employer who elect COBRA under this Plan AND who elect coverage under Medicare, Medicare will be primary to the Plan. It is IMPORTANT to note that in such an instance or situation the Plan will not make up the difference for the benefit you would have received from Medicare if you elect COBRA but fail to enroll in Medicare Parts A and B. For this reason, if you elect COBRA and are Medicare-eligible, you must also enroll in Medicare Parts A and B in order to receive the maximum level of coverage for your medical expenses.

PLEASE NOTE: See your Employer or group administrator should you have any questions regarding the ESRD primary period or other provisions of the MSP regulations and their application to you, your Spouse or any other Eligible 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.

SPECIAL ELECTION FOR EMPLOYEES AND SPOUSES AGE 65 AND OVER

If you remain actively employed with an Employer after reaching age 65, you or your Spouse may choose to remain covered under this Plan without reduction for Medicare benefits or designate Medicare as the primary payor of benefits. If you choose to remain covered under this Plan, this Plan will be the primary payor of benefits and

Medicare will be secondary. If you choose Medicare as primary, coverage under this Plan will end. If you do not specifically choose one of the options, this Plan will continue to be primary.

If you are under age 65, still working for an Employer and a participant in this Plan and your Spouse is over age 65, he or she can make his or her own choice whether Medicare or this Plan will be primary. If he or she does not make an affirmative choice, this Plan will automatically be primary.

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 under the Plan and does not mean that the Claim Administrator will pay the cost of the hospitalization, services or supplies.

EXCLUSIONS - WHAT IS NOT COVERED (CONT'D)

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, the 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.

Other services and supplies which are not Medically Necessary under the Plan.

Services or supplies that are not specifically mentioned in this benefit booklet and Summary Plan Description.

Services rendered by anyone other than a health professional as established under the terms of this benefit booklet.

Treatment not prescribed or recommended by a health care Provider.

As may be applicable with respect to expenses incurred both In or Out of Network and subject to all such provisions in the Plan, expenses exceeding the Usual and Customary, Maximum Allowable or Eligible Charge for a geographic area in which services are rendered.

Charges incurred for services rendered prior to the effective date of the Plan, prior to your effective date of coverage under the Plan, or submitted to the Plan after the deadline for Claims filing has expired.

Charges in excess of any applicable benefit limits or Lifetime maximum, or charges which the Plan Sponsor is prohibited by law or regulation from paying.

Complications arising from any non-covered surgery or treatment, except as required by law.

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 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.

Any condition, disability or expense sustained as a result of: duty as a member of the armed forces of any state or country; engaging in a war or act of war, whether declared or undeclared; participation in a civil revolution or riot; or in an intentional or accidental atomic explosion or other release of nuclear energy, whether in peacetime or wartime. An act of terrorism will not be considered an act of war if the individual seeking benefits under the Plan is, or was, not a willing participant.

EXCLUSIONS - WHAT IS NOT COVERED (CONT'D)

Services or supplies furnished, paid for, or for which benefits are provided or required by reason of past or present service of any covered family member in the armed forces of a government.

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

Educational, vocation or training services and supplies, except as specified in this benefit booklet.

Expenses for preparing or copying medical reports, itemized bills, or claim forms.

Mailing or shipping and handling expenses.

Sales tax.

Travel expenses for a Physician or covered person, except as specified in the Human Organ Transplants section of the Plan and this benefit booklet.

Investigational Services and Supplies and all related services and supplies, except as may be provided under this benefit booklet 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 this benefit booklet if not provided in connection with a qualified cancer trial program.

Custodial Care Service.

Long Term Care Service.

Expenses eligible for consideration under any other plan of the Employer.

Treatment or services rendered outside the United States of America or its territories, except for accidental injury, a medical emergency, or other services that may be covered under the Plan under the terms of the Adoption Agreement between the Plan and the Participating Employer. Treatment or services rendered to Employees of the Employer who are traveling on company business are not subject to this exclusion.

Voluntary donation of organs, except as specified in the Human Organ Transplants section of this benefit booklet.

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

Inpatient Private Duty Nursing Service.

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

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

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

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

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

EXCLUSIONS - WHAT IS NOT COVERED (CONT'D)

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

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

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

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

Kerato-refractive eye Surgery (surgery to improve nearsightedness, farsightedness, and/or astigmatism by changing the shape of the cornea, including but not limited to LASEK, LASIK, radial keratotomy and keratomileusis Surgery), unless otherwise associated with treatment for diseases of the eye.

Eye examinations for the diagnosis or treatment of a refractive error, including fitting of eyeglasses or lenses, orthoptics, vision therapy or supplies, unless such treatment is due to a covered illness or accidental injury.

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 this benefit booklet or as required to comply with the Affordable Care Act.

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

Maintenance Care.

Speech Therapy when rendered for the treatment of psychosocial speech delay, behavioral problems (including impulsive behavior and impulsivity syndrome), attention disorder, conceptual handicap or mental retardation.

Sex change Surgery.

Penile prosthetic implants.

Expenses related to insertion or maintenance of an artificial heart.

Expenses for education, counseling, job training or care for learning disorders or behavioral problems, whether or not services are rendered in a facility that also provides medical and/or mental/nervous treatment.

Treatment of behavioral or conduct disorders.

Genetic counseling and/or testing, except as may be specified in the Covered Services.

Massage therapy or rolfing.

Acupuncture.

Adoption expenses.

Surrogate expenses.

EXCLUSIONS - WHAT IS NOT COVERED (CONT'D)

Hypnosis, unless in conjunction with the treatment of a covered illness and administered or over seen by a certified Professional Provider.

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. Reversals of any reproductive sterilization procedures.

Surgical impregnation procedures, including but not limited to, artificial insemination, in vitro fertilization and fetal and embryo implants.

Boutique Medical coverage (whereby a member pays money up-front to be guaranteed office visit hours with a Physician that is convenient to the member).

Drugs, medicines or supplies that do not require a Physician's prescription.

Equipment such as air-conditioners, air-purifiers, dehumidifiers, heating pads, hot water bottles, water beds, swimming pools, hot tubs and any other equipment or clothing which could be used in the absence of an illness or injury.

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

Services and supplies to the extent benefits are duplicated because the Spouse, parent and/or child are covered separately under this Healthcare Plan.

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

Residential Treatment Centers services, except for Inpatient Substance Use Disorders or Inpatient Mental Illness specifically mentioned in this benefit booklet.

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

Wigs (also referred to as cranial prostheses), unless otherwise specified in this benefit booklet or in the case of Crohn's disease.

Services and supplies rendered or provided for human organ or tissue transplants other than those specifically named in this benefit booklet.

Elective abortions except as otherwise noted in this booklet.

Reversals of sterilization.

Maternity services for dependent children or children covered to age 26 as required by the Affordable Care Act.

Biofeedback.

Marriage and family therapy or counseling.

Services rendered by a Licensed Marriage and Family Therapist.

Sex counseling.

EXCLUSIONS - WHAT IS NOT COVERED (CONT'D)

Any condition, disability or expense sustained as a result of being engaged in an illegal occupation of the commission or attempted of an illegal or criminal act.

Sports physicals, unless coverage is required to comply with the Affordable Care Act and/or other governmental regulations that apply to this Plan.

Treatment services relating to autism or autistic related disorders.

Medical or Dental services rendered by an immediate family member. Immediate family members include; husband, wife, natural or adoptive parent, child and sibling, stepparent, stepchild, stepbrother, stepsister, father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, sister-in-law, grandparent, grandchild, spouse of grandparent or grandchild.

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 insure that you receive all of the coverage to which you are entitled but no more than the actual cost of the care received. In other words, the total payment from all of your coverages together will not add up to be more than the total charges that you have incurred. It is your obligation to notify the Claim Administrator of the existence of such other group coverages. 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 or plan which covers the child as a dependent of the parent with custody of the child will be determined before the benefits of a contract or plan 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 or plan which covers the child as a dependent of the parent with custody shall be determined before the benefits of a contract or plan which covers that child as a dependent of the stepparent, and the benefits of a contract or plan which covers that child as a dependent of the stepparent will be determined before the benefits of a contract or plan 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 or plan which covers the child as a dependent of the parent with such financial responsibility shall be determined before the benefits of any other contract or plan which covers the child as a dependent child. It is the obligation of the person claiming benefits to notify the Claim Administrator, and upon its request to provide a copy, of such court decree.

3. If neither of the above rules apply, then the coverage that has been in effect the longest is primary. The only time these rules will not apply is if the other group benefit program does not include a COB provision. In that case, the other group program is automatically primary.

The Claim Administrator has the right in administering these COB provisions to:

- pay any other organization an amount which it determines to be warranted if payments which should have been made by the Claim Administrator have been made by such other organization under any other group program.
- recover any overpayment which the Claim Administrator may have made to you, any Provider, insurance company, person or other organization.

CONTINUATION COVERAGE RIGHTS UNDER COBRA

Introduction

You are receiving this notice because you have recently become covered under your Employer's group health plan (the Plan) or you are receiving another copy of the Plan's benefit booklet and Summary Plan Description as an active status employee of your Employer. 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 your right to receive it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

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 or your Employer's Human Resource Representative.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally does not accept late enrollees. Also, coverage may be available through Medicaid. Some of these options may cost less than COBRA continuation coverage. You can learn more about these options at www.healthcare.gov.

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 entitled to 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 entitled to 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."

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, 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 eligible 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 any special notice procedures pertaining to this coverage, 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. This extension is only available if the second qualifying event would have caused the Spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Termination of Continuation Coverage

In no event will coverage last beyond the 18-month, 29-month or 36-month continuation coverage period. However, the law also provides that your continuation coverage may be terminated for any of the following reasons:

- The Employers no longer provide group health plan coverage to any of their employees;
- The premium paid for continuation coverage is not paid on time;
- You or your dependents become entitled to Medicare;
- You become covered under another group health plan (provided pre-existing condition exclusions or limitations under the group health care plan do not apply);
- You or your dependent whose disability resulted in being entitled to the disability extension is no longer disabled.

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to your Employer or the Plan Administrator. For more information about your rights under ERISA, including COBRA, the Patient Protection and Affordable Care Act 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.) For information about the Marketplace, visit www.healthcare.gov.

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.

CLAIM FILING 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 ID 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 Employer's Human Resources or 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 must be filed no later than twelve (12) months after the date a service is received. Claims not filed within twelve (12) months from the date a service is received, 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 was unable to transmit a Claim or you received benefits from a non-Participating Prescription Drug Provider. To do so, follow these instructions:

1. Complete a prescription drug Claim Form. These forms are available from your Employer's Human Resources or 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:

Blue Cross and Blue Shield of Illinois
P.O. Box 14624
Lexington, KY 40512-4624

In any case, Claims must be filed no later than twelve (12) months after the date a service is received. Claims not filed within twelve (12) months from the date a service is received will not be eligible for payment.

INTERNAL CLAIMS DETERMINATIONS AND APPEALS PROCESS

INITIAL CLAIMS DETERMINATIONS

The Claim Administrator will usually pay all Claims within 30 days of receipt of all information required to process a Claim. The Claim Administrator will usually notify you, your valid assignee or your authorized representative, when all information required to pay a Claim 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 you fail to follow the procedures for filing a pre-service claim (as defined below), you will be notified within 5 days (or within 24 hours in the case of a failure regarding an urgent care/expedited clinical claim [as defined below]). Notification may be oral unless the claimant requests written notification.

If a Claim is Denied or Not Paid in Full

If a claim for benefits is denied in whole or in part, you will receive a notice from the Claim Administrator within the following time limits:

1. For non-urgent pre-service claims, within 15 days after receipt of the claim by the Claim Administrator. A "pre-service claim" is any non-urgent request for benefits or for 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.
2. For post-service Claims, within 30 days after receipt of the Claim by the Claim Administrator. A "post-service claim" is a Claim as defined above.

If the Claim Administrator determines that special circumstances require an extension of time for processing the claim, for non-urgent pre-service and post-service claims, the Claim Administrator shall notify you or your authorized representative in writing of the need for extension, the reason for the extension, and the expected date of decision within the initial period. In no event shall such extension exceed 15 days from the end of such initial period. If an extension is necessary because additional information is needed from you, the notice of extension shall also specifically describe the missing information, and you shall have at least 45 days from receipt of the notice within which to provide the requested information.

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

- a. The reasons for denial;
- b. A reference to the benefit plan provisions on which the denial is based;
- c. A description of additional information which may be necessary to perfect an appeal 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 denial codes with their meanings and the standards used;
- 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) and a statement of your right, if any, to bring a civil action under Section 502(a) of ERISA following a final denial on internal review/appeal;
- f. In certain situations, a statement in non-English language(s) that future notices of Claim denials and certain other benefit information may be available in such non-English language(s);

- g. 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;
 - h. 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;
 - i. An explanation of the scientific or clinical judgment relied on in the determination as applied to claimant's medical circumstances, if the denial was based on medical necessity, experimental treatment or similar exclusion, or a statement that such explanation will be provided free of charge upon request;
 - j. In the case of a denial of an urgent care/expedited clinical claim, a description of the expedited review procedure applicable to such claims. An urgent care/expedited claim decision may be provided orally, so long as written notice is furnished to the claimant within 3 days of oral notification;
 - k. Contact information for applicable office of health insurance consumer assistance or ombudsman.
- 3. For benefit determinations relating to urgent care/expedited clinical claim (as defined below), such notice will be provided no later than 24 hours after the receipt of your claim for benefits, unless you fail to provide sufficient information. You will be notified of the missing information and will have no less than 48 hours to provide the information. A benefit determination will be made within 48 hours after the missing information is received.
 - 4. 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.

An "urgent care/expedited 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.

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 a claim denial (or partial denial), then you have the right to a claim review/appeal as described in the CLAIM APPEAL PROCEDURES.

To pursue an Inquiry or a Complaint, you may contact **Customer Service** at the number on the back of your ID card, or you may write to:

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

When you contact Customer Service to pursue an Inquiry or Complaint, you will receive a written 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.

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 Participating Provider.

CLAIM APPEAL PROCEDURES - DEFINITIONS

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. 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 ID card.

An **“Adverse Benefit Determination”** means a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment for, a benefit resulting from the application of utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate. If an ongoing course of treatment had been approved by the Claim Administrator, your Employer or the Plan Administrator and the Claim Administrator, the Plan 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.

In addition, an Adverse Benefit Determination, also includes an “Adverse Determination.” An **“Adverse Determination”** means a determination by the Claim Administrator or its designated utilization review organization that an admission, availability of care, continued stay, or other health care service that is a Covered Service has been reviewed and, based upon the information provided, does not meet the Claim Administrator’s requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness, and the requested service or payment for the service is therefore denied, reduced, or terminated. For purposes of this benefit program, we will refer to both an Adverse Determination and an Adverse Benefit Determination as an Adverse Benefit Determination, unless indicated otherwise.

A **“Final Internal Adverse Benefit Determination”** means an Adverse Benefit Determination that has been upheld by the Claim Administrator or the Plan Administrator at the completion of the Claim Administrator’s internal review/appeal process.

CLAIM APPEAL PROCEDURES

If you have received an Adverse Benefit Determination, you may have your Claim reviewed on appeal. The Claim Administrator will review its decision in accordance with the following procedures. The following review procedures will also be used for Claim Administrator’s (i) coverage determinations that are related to non-urgent care that you have not yet received if approval by your plan is a condition of your opportunity to maximize your benefits and (ii) coverage determinations that are related to care that you are receiving at the same time as the determination. Claim reviews are commonly referred to as “appeals.”

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. You may call 1-877-284-9302 or send your request to:

Claim Review Section
Health Care Service Corporation
P.O. Box 2401
Chicago, Illinois 60690

In support of your Claim review, you have the option of presenting evidence and testimony to the Claim Administrator, by phone or in person at a location of the Claim Administrator's choice. 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 Claim Administrator will provide you or your authorized representative with any new or additional evidence or rationale and any other information and documents used in the denial or the review of your Claim without regard to whether such information was considered in the initial determination. No deference will be given to the initial Adverse Benefit Determination. Such new or additional evidence or rationale and information will be provided to you or your authorized representative sufficiently in advance of the date a final decision on appeal is made in order to give you a chance to respond. 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 denial of your Claim. 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 or the Plan Administrator.

Urgent Care/Expedited Clinical Appeals

If your appeal relates to an urgent care/expedited clinical claim, or health care services, including but not limited to, procedures or treatments ordered by a health care provider, the denial of which could significantly increase the risk to the claimant's health, then you may be entitled to an appeal on an expedited basis. 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 urgent care/expedited pre-service or concurrent clinical appeal, the Claim Administrator will notify the party filing the appeal, as soon as possible, but no more than 24 hours after submission of the appeal, of all the information needed to review the appeal. Additional information must be submitted within 24 hours of request. The Claim Administrator shall render a determination on the appeal within 24 hours after it receives the requested information.

Other Appeals

Upon receipt of a non-urgent pre-service or post-service appeal the Claim Administrator shall render a determination of the appeal within 30 days after the appeal has been received by the Claim Administrator or such other time as required or permitted by law.

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 offices are open from 8:45 A.M. to 4:45 P.M., Monday through Friday.

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

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

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, orally of its determination followed-up by a written notice of the determination.

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 information about how to obtain diagnosis, treatment and denial codes with their meanings;
4. An explanation of the Claim Administrator's external review processes (and how to initiate 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 denial on external appeal;
5. In certain situations, a statement in non-English language(s) that future notices of Claim denials and certain other benefit information may be available in such non-English language(s);
6. 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;
7. 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;
8. 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;
9. A description of the standard that was used in denying the claim and a discussion of the decision.

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

If an appeal is not resolved to your satisfaction, you may appeal the Claim Administrator's decision to the Illinois Department of Insurance. The Illinois Department of Insurance will notify the Claim Administrator of the appeal. The Claim Administrator will have 21 days to respond to the Illinois Department of Insurance.

Some of the operations of the Claim Administrator are regulated by the Illinois Department of Insurance. Filing an appeal does not prevent you from filing a Complaint with the Illinois Department of Insurance or keep the Illinois Department of Insurance from investigating a Complaint.

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).

An “**Adverse Benefit Determination**” means a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment for, a benefit resulting from the application of 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 the Plan Administrator and the Claim Administrator or the Plan Administrator 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 the Claim Administrator completes 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, the Claim Administrator 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, the 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 with 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 denial 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 denial);
 - (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

Request for expedited external review. The 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.
1. **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 the STANDARD EXTERNAL REVIEW section above.
 2. **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.
 3. **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

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 Marmon Healthcare 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. The Plan Sponsor has been advised that the Claim Administrator may receive such payments, discounts and/or other allowances during the term of the agreement between the Plan Sponsor and the Claim Administrator. Neither the Plan Sponsor 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 the Plan Sponsor are entitled to any part of these savings.

Other Blue Cross and Blue Shields' Separate Financial Arrangements with Providers Blue Card

The Claim Administrator hereby informs you that other Blue Cross and Blue Shield Plans outside of Illinois ("Host Blue") may have contracts similar to the contracts described above with certain Providers ("Host Blue Providers") in their service area.

When you receive health care services through BlueCard outside of Illinois and from a Provider which does not have a contract with the Claim Administrator, the amount you pay for Covered Services is calculated on the lower of:

- The billed charges for your Covered Services; or
- The negotiated price that the Host Blue passes on to the Claim Administrator.

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

- a. Suppose you receive covered medical 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 consist of a simple discount which reflects the actual price paid by the Host Blue. Sometimes, however, it is an estimated price that factors into the actual price increases or reductions to reflect aggregate payment from expected settlements, withholds, any other contingent payment arrangements and non-claims transactions with your health care provider or with a specified group of providers. The negotiated price may also be billed charges reduced to reflect an average expected savings with your health care provider or with a specified group of providers. The price that reflects average savings may result in greater variation (more or less) from the actual price paid than will the estimated price. The negotiated price will also be adjusted in the future to correct for over- or underestimation of past prices. However, the amount you pay is considered a final price.

Statutes in a small number of states may require the Host Blue to use a basis for calculating your liability for Covered Services that does not reflect the entire savings realized, or expected to be realized, on a particular

claim or to add a surcharge. Should any state statutes mandate your liability calculation methods that differ from the usual BlueCard method noted above or require a surcharge, the Claim Administrator would then calculate your liability for any covered health care services in accordance with the applicable state statute in effect at the time you received your care.

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 Healthcare Plan will be calculated on the basis of the Servicing Plan Provider’s Eligible Charge for Covered Services rendered to you or the cost agreed upon between the Servicing Plan and the Claim Administrator for Covered Services that the Servicing Plan passes to the Claim Administrator, whichever is lower.

Often, the agreed upon cost is a simple discount. Sometimes, however, the agreed upon cost may represent either an estimated discount or an average discount received or expected by the Servicing Plan based on separate financial arrangements with Servicing Plan Providers. In other instances, laws in a small number of states dictate the basis upon which the Coinsurance is calculated. When Covered Services are rendered in those states, the Coinsurance amount will be calculated using the state’s statutory method.

Claim Administrator’s Separate Financial Arrangements with 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 Healthcare Plan. Under its contracts with Participating Prescription Drug Providers, the Claim Administrator may receive from these Providers discounts for prescription drugs dispensed to you.

Coinsurance amounts payable by you under this Healthcare 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.

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. Neither the Employer nor you are entitled to receive any portion of such rebates as they are figured into the pricing of the product.

2. PAYMENT OF CLAIMS AND ASSIGNMENT OF BENEFITS

- a. Under this Healthcare 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 Healthcare 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 Healthcare 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.

3. YOUR PROVIDER RELATIONSHIPS

- a. The choice of a Provider is solely your choice and the Claim Administrator and the Employer 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 and the Participating Employer are 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 or the Participating Employer. Any contractual relationship between a Physician and an Administrator Provider shall not be construed to mean that the Claim Administrator is providing professional service.
- c. The use of an adjective such as Participating, Administrator or approved in modifying a Provider shall in no way be construed as a recommendation, referral or any other statement as to the ability or quality of such Provider. In addition, the omission, non-use or non-designation of Participating, Administrator, approved or any similar modifier or the use of a term such as Non-Administrator or Non-Participating should not be construed as carrying any statement or inference, negative or positive, as to the skill or quality of such Provider.

- d. Each Provider provides Covered Services only to you and does not deal with or provide any services to your Employer (other than as an individual Covered Person, if applicable) or your Employer's ERISA Health Benefit Program.

4. NOTICES

Any information or notice which you furnish to the Claim Administrator under the Marmon Healthcare 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.

5. LIMITATIONS OF ACTIONS

No legal action may be brought to recover under the Marmon Healthcare 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 one (1) year after the time a Claim is required to be furnished to the Claim Administrator in accordance with the requirements described in this benefit booklet.

6. INFORMATION AND RECORDS

You agree that it is your responsibility to insure that any Provider, other Blue Cross and Blue Shield Plan, insurance company, employee benefit association, government body or program, any other person or entity, having knowledge of or records relating to (a) any illness or injury for which a Claim or Claims for benefits are made under this Healthcare 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.

7. RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION

To the extent permitted by federal medical privacy regulations issued at 45 CFR Part 164 (the "medical privacy rules"), the Plan may, without the consent of or notice to any person, release to or obtain from any organization or person, information needed to implement Plan provisions, including medical information. When you request benefits, you may be required to furnish or authorize the release of all the information required to implement Plan provisions. Except to the extent provided under the medical privacy rules, your failure to fully cooperate will result in a denial of the requested benefits and the Plan will have no further liability for such benefits.

8. PAYMENT OF CLAIMS AND ASSIGNMENT OF BENEFITS

Under this 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.

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.

A Covered Person's claim for benefits under this Plan is expressly non-assignable and non-transferable in whole or in part to any person or entity, including any Provider, at any time before or after Covered Services are rendered to a Covered Person. Coverage under this 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.

9. MEDICARE ELIGIBILITY

It is also your responsibility to furnish to the Plan Administrator and/or your Employer or group administrator information regarding your or your covered dependents becoming eligible for Medicare, termination of Medicare eligibility or any changes in Medicare eligibility status in order that the Plan Administrator may make Claim Payments in accordance with MSP laws.

10. RESTITUTION TO THE PLAN AND SUBROGATION

As a condition to participating in and receiving benefits under the Plan, all covered persons (as described below) agree:

- (i) to reimburse the Plan for any benefits paid to or on behalf of a covered person relating to an illness or injury when such benefits or any other amounts are recovered (regardless of how that compensation may be characterized; whether the recovery is the result of a court judgment, arbitration award, compromise settlement, or any other arrangement; or whether the other party admits liability) from another party (including the covered person's own insurer under an automobile or other policy). The preceding sentence is not an imposition of personal liability, but reflects the equitable obligation to reimburse the Plan from any recovery by the covered person. If the covered person fails to reimburse the Plan to the extent of the benefits paid by the Plan, the Plan may elect to recover the expenses by recoupment from past or future claims made by any covered person. The reimbursement required under this provision will not be reduced to reflect any costs or attorneys' fees incurred by the covered person in obtaining any recovery from another party unless specifically agreed to, in writing, by the Plan Administrator, in the exercise of its sole discretion.
- (ii) without limiting (i) above, to subrogate the Plan to any and all claims, causes of action or rights that the covered person may have or that may arise against any party that may be liable for the covered person's illness or injury (including the covered person's own insurer under an automobile or other policy) for which the covered person claims an entitlement to benefits under the Plan to the extent of the reasonable value of the benefits paid to the covered person under the Plan. The preceding sentence is not an imposition of personal liability, but reflects an equitable right of the Plan to restore plan assets to the Plan for the benefit of all participants. The Plan may assert this subrogation right independently of the covered person. The costs and attorneys' fees incurred by the Plan in matters related to subrogation will be borne solely by the Plan, and the costs and attorneys' fees incurred by the covered person will be borne by such covered person.

A “covered person” for purposes of this Section includes anyone on whose behalf the Plan pays or provides any benefit, including, but not limited to, the minor child or dependent of any participant in the Plan or any person entitled to receive benefits under the Plan.

In order to secure the reimbursement and subrogation rights of the Plan under this section, each covered person hereby:

- (i) grants to the Plan a first priority lien against the proceeds of any recovery relating to an illness or injury received by such covered person;
- (ii) assigns to the Plan any benefits the covered person may have under any automobile policy or other insurance coverage to the extent of the Plan’s claim for reimbursement;
- (iii) agrees that the covered person will hold any recovery in constructive trust for the benefit of the Plan and all its participants who have contributed to the funding of the Plan;
- (iv) agrees that the covered person will notify the Plan Administrator in writing within 45 days of the date when the covered person gives notice to any party, including an attorney, of the intention to pursue or investigate a claim to recover compensation for an illness or injury;
- (v) agrees that the covered person will notify the Plan Administrator in writing within 45 days before entering into any settlement or any other arrangement under which another party (including the covered person’s own insurer under an automobile or other policy) agrees to compensate such covered person for an illness or injury; and
- (vi) acknowledges that the Plan has the right to intervene in any action wherein the covered person makes a claim for compensation for an illness or injury, and consents to such intervention by the Plan.

The Plan’s right of recovery and right of subrogation are not subject to any covered person first being made whole. The “make whole” rule does not apply to the Plan.

Each covered person agrees to cooperate with the Plan and its agents in order to protect the Plan’s right of reimbursement and right of subrogation. Cooperation includes signing and delivering such documents as the Plan or its agents reasonably request, providing the Plan or its agents any relevant information, taking such actions as the Plan or its agents reasonably request to assist the Plan in making a full recovery of the reasonable value of the benefits provided, and obtaining the consent of the Plan or its agents before releasing any party from liability for payment of medical expenses. Each covered person agrees that he or she will not take any action that, in any way, prejudices the Plan’s right of reimbursement or right of subrogation.

By accepting benefits under this Plan, you agree to the reimbursement/subrogation provisions set forth in this document. Once you have been paid benefits under the Plan, payment of any future benefits is conditioned upon your compliance with the reimbursement/subrogation provisions set forth in this document.

The Plan reserves the right to pursue recovery from third parties if the covered person decides not to attempt recovery.

11. RECOVERY OF EXCESS PAYMENTS

Whenever payments have been made in excess of the amount necessary to satisfy the provisions of this Plan, the Plan has the right to recover these excess payments from any individual (including yourself), insurance company or other organization to whom the excess payments were made or to withhold payment, if necessary, on future benefits until the overpayment is recovered.

If excess payments were made for services rendered to your dependent(s), the Plan has the right to withhold payment on your future benefits until the overpayment is recovered. Further, whenever payments have been made based on fraudulent information provided by you, the Plan will exercise all available legal rights, including its right to withhold payment on future benefits, until the overpayment is recovered.

12. RELIANCE ON DOCUMENTS AND INFORMATION

Information required by the Plan Administrator may be provided in any form or document that the Plan Administrator considers acceptable and reliable. The Plan Administrator relies on the information provided by you and others when evaluating coverage and benefits under the Plan. All such information, therefore, must be accurate, truthful and complete. The Plan Administrator is entitled to conclusively rely upon, and will be protected for any action taken in good faith in relying upon, any information provided to the Plan Administrator. In addition, any fraudulent statement, omission or concealment of facts, misrepresentation, or incorrect information may result in the denial of the claim, cancellation or rescission of coverage, or any other legal remedy available to the Plan.

13. NO WAIVER

The failure of the Plan Administrator to enforce strictly any term or provision of this Plan will not be construed as a waiver of such term or provision. The Plan Administrator reserves the right to enforce strictly any term or provision of this Plan at any time.

14. NOT A CONTRACT OF EMPLOYMENT

Nothing contained in this Plan will be construed as a contract or condition of employment between the Employer and any employee. All employees are subject to discharge to the same extent as if this Plan had never been adopted.

15. ADDITIONAL INFORMATION ON COVERED AND EXCLUDED BENEFITS

If you would like to receive additional information regarding a specific drug, medical test, device or procedure which is either a covered or excluded benefit under this Plan, you may contact the Claim Administrator at the telephone number provided on your identification card.

16. RIGHT TO AMEND OR TERMINATE PLAN

The Plan Sponsor reserves the right to amend, modify or terminate the Plan in any manner, for any reason, at any time. Any action required or permitted to be taken by the Plan Sponsor with respect to the Plan shall be by action of The Marmon Group LLC, to whom the Plan Sponsor has delegated this right, or by a person or persons authorized by The Marmon Group LLC.

17. INTERPRETATION OF PLAN

The Plan Administrator or its delegate(s), where such responsibility has been properly delegated to others, shall have complete discretionary authority to determine the standard of proof required in any case, to determine eligibility for Plan benefits, to apply, construe and interpret the terms of the Plan, and to interpret any ambiguous or uncertain terms or resolve any disputes arising from Plan language.

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.")

Refer to the GENERAL PROVISIONS section of this booklet for additional information relating to subrogation relating to benefits otherwise provided under the terms of the Healthcare Plan.

END OF BENEFIT BOOKLET

The information which follows is provided to you by The Marmon Group LLC in its capacity of Plan Administrator. The Claim Administrator is not responsible for its contents.

Newborns' and Mother's Health Protection Act Notice

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending Provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law require that a Provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Women's Health and Cancer Rights Act Notice

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending Physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Protheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this Plan.

ERISA RIGHTS OF PLAN PARTICIPANTS

As a participant in the Marmon Healthcare Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

Receive Information about Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure room of the Employee Benefits Security Administration (formerly Pension and Welfare Benefit Administration.)

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report, if such report is necessary.

Continue Group Health Plan Coverage

Continue health care coverage for yourself, Spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Plan Fiduciary Prudent Actions

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your Employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, and have the plan review and reconsider your claim, all within certain time schedules. You must receive a written explanation of the reasons for the denial.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part,

you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees – for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact your Employer's Human Resources Department or if none exists, the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

HIPAA NOTICE OF PRIVACY PRACTICES

As a participant in the Marmon Healthcare Plan (the “Plan”), you are entitled to certain rights concerning your protected health information under the Health Insurance Portability and Accountability Act (HIPAA). This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Uses and Disclosures of Information Without Your Written Authorization

Under the law, the Plan may use or disclose your protected health information under certain circumstances without your permission. The term “protected health information” or “PHI” includes all individually identifiable health information related to your past, present or future physical or mental health condition or to payment for health care. The term also includes genetic information (such as family medical history and information about an individual’s receipt of genetic services or tests). PHI includes information maintained by the Plan in oral, written or electronic form.

The following categories describe the different ways that the Plan may use and disclose your protected health information without your permission. However, not every use or disclosure is listed.

Treatment. The Plan may use or disclose your protected health information which can include facilitating medical treatment or services by providers. For example, the Plan may share your protected health information with a pharmacist if a question arises as to whether there might be a contraindication for a newly prescribed medication.

Medical information obtained through administrative services, including medical claims and pharmacy claims, may be used to help identify the appropriate level of care support, Case Management or other programs available to you as described in the Plan. You may receive prescription drug refill reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. Your health information also may be used for quality assessment and improvement activities related to your medical benefits. Medical information obtained through these administrative services will not be used to make employment and personnel decisions.

Payment. The Plan may use or disclose your protected health information which can include eligibility determinations, reviewing services for medical necessity or appropriateness, utilization management activities, claims management, and billing. For example, the Plan may share your protected health information with another health plan in order to coordinate payment of benefits.

Health Care Operations. The Plan may use or disclose your protected health information which can include activities by the Plan (and in limited circumstances other plans or providers) such as wellness and risk assessment programs, quality assessment and improvement activities, customer service, and internal grievance resolution. Health care operations also include vendor evaluations, credentialing, training, accreditation activities, underwriting, premium rating, arranging for medical review and audit activities, and business planning and development. For example, the Plan may use information about your claims to project future benefit costs.

We are prohibited from using or disclosing genetic information about you for underwriting purposes.

Business Associates. The Plan may disclose your medical information to its Business Associates to perform various functions on the Plan’s behalf. A Business Associate is a person who, on behalf of the Plan, creates, receives, maintains, or transmits protected health information for purposes of treatment, payment, health care operations, or to provide services, such as legal, actuarial, accounting, consulting, data aggregation, management, administrative, accreditation or financial services to the Plan. The Claim Administrator is considered a Business Associate of the Plan. In order to perform these functions, Business Associates may receive, create, maintain, use and/or disclose your protected health information, but only after they agree in writing with the Plan to implement appropriate safeguards regarding your protected health information. For example, the Plan may disclose your protected health information to a Business Associate to administer claims. All Business Associates are directly subject to certain provisions of the HIPAA Privacy Rule and all provisions of the Security Rule, and must, therefore, comply with such legal requirements and with their contractual obligations set forth under the Business Associate Agreement with the Plan.

The amount of health information used or disclosed will be limited to the minimum necessary for these purposes. The Plan may also contact you to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Use and Disclosure of Information to and from the Plan Sponsor

The Plan may disclose protected health information to Marmon Holdings, Inc. (the “Plan Sponsor”) under limited circumstances.

The Plan may disclose “summary health information” to the Plan Sponsor for the purposes of obtaining premium bids, insurance coverage, or modifying, amending or terminating the Plan. Summary health information is information that summarizes participants’ claims information, but from which names and other identifying information has been removed.

The Plan will disclose protected health information other than summary health information to the Plan Sponsor for the purposes described below only upon receipt of a certification by the Plan Sponsor that the plan documents have been amended to incorporate and to abide by these privacy provisions. If such certification is received, a limited number of employees designated by the Plan Administrator will have access to protected health information for the purposes of carrying out plan treatment, payment and health care operations functions in the ordinary course of business. The Plan may disclose to the Plan Sponsor information on whether an individual is participating in the Plan, or has enrolled or dis-enrolled in a health plan option offered by the Plan. These employees are specified (by title) in the Plan’s HIPAA Privacy Policies and Procedures.

These employees will only use protected health information for the foregoing plan administration functions, consistent with the Plan’s Privacy Policies and Procedure and the Standards for Privacy of Individually Identifiable Health Information.

The Plan Sponsor must make available its internal practices, books, and records relating to the use and disclosure of protected health information received from the Plan to the Secretary of the U.S. Department of Health and Human Services for purposes of determining compliance with the Standards for Privacy of Individually Identifiable Health Information.

In addition, you should know that the Plan Sponsor cannot and will not use health information obtained from the Plan for any employment-related actions. However, health information collected by the Plan Sponsor from other sources, for example, under the Family and Medical Leave Act, Americans with Disabilities Act, or worker’s compensation is not protected under HIPAA, although this type of information may be protected under other federal or state laws.

Other Permitted Uses and Disclosures of Health Information by the Plan

In addition to the foregoing, the Plan is permitted or required to use your protected health information without your authorization in the following circumstances: the Plan is permitted to disclose protected health information without your authorization for public health activities (to a public health authority authorized by law); health oversight activities (to a health oversight agency); research projects that are subject to a special government approval process; and judicial and administrative proceedings, provided certain safeguards are complied with. The Plan also is permitted to disclose protected health information to law enforcement officials when required by law; to a coroner, medical examiner or funeral director for certain purposes; for organ and tissue donation if you are a donor; for national security purposes; and to avert a serious threat to health or safety. The Plan is also required to disclose protected health information to you or your personal representative to the extent you request it and have a right of access to the information, and to the U.S. Department of Health and Human Services on request for complaint investigation or compliance review.

Security Standards for Electronic PHI

These security standards apply to PHI that is transmitted by electronic media or maintained in electronic media (“electronic PHI”). Specifically, the Plan Sponsor must:

1. Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the electronic PHI that it creates, receives, maintains or transmits on behalf of the Plan;
2. Ensure that the adequate separation required by the HIPAA privacy provisions of this Notice is supported by reasonable and appropriate security measures;
3. Ensure that any agents, including subcontractors, to whom the Plan Sponsor provides electronic PHI, agree to implement reasonable and appropriate security measures to protect such electronic PHI; and
4. Report to the Plan any security incident of which it becomes aware.

Uses and Disclosures With Your Written Authorization

The Plan will not use or disclose your protected health information without your written authorization unless the use or disclosure is explicitly described in this notice. Certain uses and disclosures of PHI require an individual authorization, including uses and disclosures for marketing purposes, disclosures that constitute a “sale” of PHI, and most uses and disclosures of psychotherapy notes. If you give the Plan written authorization to use or disclose your protected health information, you have a right to revoke the authorization at any time in writing as allowed under the HIPAA rules. However, you can’t revoke your authorization if the Plan has taken action relying on it. In other words, you can’t revoke your authorization with respect to disclosures the Plan has already made.

Your Individual Rights: Access, Amendment and Accounting of Health Information

You have a right to request access to inspect and obtain a copy of your protected health information that the Plan and the Plan’s business associates maintain in a designated record set. You may request your records be in paper or electronic format. In certain limited circumstances, the Plan has a right to deny your request for access, and you have the right to request a review of that denial, pursuant to the provisions of 45 CFR § 164.524. The designated record set that the Plan maintains includes documentation about enrollment, payment, claims adjudication, or case/medical management. To request access to your protected health information or to inspect and copy your protected health information, contact the Plan’s Privacy Officer at the following address: Health/Dental Plans Privacy Officer, c/o Human Resources Dept., Marmon Holdings, Inc., 181 West Madison St., 26th Floor, Chicago, IL 60602, 312-372-9500.

If you feel the protected information maintained by the Plan about you is incorrect, incomplete or needs to be amended, you have a right to request that the Plan amend your protected health information that the Plan and the Plan’s business associates maintain in a designated record set. The Plan has established procedures in its Privacy Policies and Procedures to allow amendment to your protected health information. The Plan has a right to deny your request for amendment for certain reasons, and you have the right to attach a statement of disagreement, pursuant to the provisions of 45 CFR § 164.526. To request an amendment to your protected health information, contact the Plan’s Privacy Officer at the following address: Health/Dental Plans Privacy Officer, c/o Human Resources Dept., Marmon Holdings, Inc., 181 West Madison St., 26th Floor, Chicago, IL 60602, 312-372-9500.

Pursuant to 45 CFR § 164.528, you also have a right to request an accounting of disclosures of your protected health information made by the Plan in the six years prior to the date on which the accounting is requested, beginning with the effective date of the Standards for Privacy of Individually Identifiable Health Information, which is April 14, 2003.

Example 1: You request an accounting on September 14, 2003. The Plan is obligated to account for disclosures made from April 14, 2003 through September 14, 2003.

Example 2: You request an accounting on September 14, 2010. The Plan is obligated to account for disclosures made from September 14, 2004 through September 14, 2010.

The Plan does not have to account for disclosures made:

- to you;
- to carry out plan treatment, payment and health care operations;
- pursuant to your written authorization;
- incident to a use or disclosure otherwise permitted under the Standards for Privacy of Individually Identifiable Health Information;
- for national security or intelligence purposes or to law enforcement officials;
- as part of a limited data set for specified purposes(protected health information that excludes all direct identifiers and satisfies other requirements);
- prior to April 14, 2003; or
- for other reasons listed in 45 CFR § 164.528.

To request an accounting of disclosures of your protected health information, contact the Plan's Privacy Officer at the following address: Health/Dental Plans Privacy Officer, c/o Human Resources Dept., Marmon Holdings, Inc., 181 West Madison St., 26th Floor, Chicago, IL 60602, 312-372-9500.

You have the right to request a restriction or limitation on the protected health information that the Plan uses or discloses about you for treatment, payment or health care operations, including restrictions on information released to an individual or family member involved in your care or payment for it, except to the extent such information is needed for your emergency medical treatment. The Plan is not required to agree to such a restriction. You also have the right to request that the Plan communicate with you about medical matters in a confidential manner, such as by alternate means or at alternative locations. The Plan is required to agree to these alternatives if conventional methods of disclosure could otherwise place you in danger.

Also, you may be contacted for fundraising purposes; however, you have the right to opt out of such fundraising communications.

Copy of Notice

You have the right to request a copy of this notice at any time. Even if you agreed to receive this notice electronically, you still have the right to ask the Plan for a paper copy of this notice as well. To obtain a copy, contact the Plan's Privacy Officer at the following address: Health/Dental Plans Privacy Officer, c/o Human Resources Dept., Marmon Holdings, Inc., 181 West Madison St., 26th Floor, Chicago, IL 60602, 312-372-9500.

Right to be Notified Following a Breach of Unsecured PHI

You have the right to and will receive a notification if the Plan Sponsor or one of its Business Associates has a breach of information security involving your unsecured protected health information.

Complaints

If you believe your privacy rights have been violated, you may complain to the Plan's Privacy Officer at the following address: Health/Dental Plans Privacy Officer, c/o Human Resources Dept., Marmon Holdings, Inc., 181 West Madison St., 26th Floor, Chicago, IL 60602, 312-372-9500. You also may complain to the Secretary of the Department of Health and Human Services at Hubert H. Humphrey Building, 200 Independence Ave. SW, Washington, DC 20201. You will not be retaliated against for filing a complaint.

Changes to This Notice

The Plan is required by law to maintain the privacy of your protected health information and to provide you with this notice of its legal duties and privacy practices with respect to protected health information. The Plan is required to abide by the terms of this notice, or any notice currently in effect. The Plan reserves the right to change the terms of this notice and to make the new notice provisions effective for all protected health information that it maintains. If this notice is materially changed, the Plan will distribute a new notice to you, either directly, via a new summary plan description or summary of material modifications or in accordance with established procedures for distributing privacy notices to employees of Employers participating in the Plan at the time the notice is issued.

Effective Date

This notice is effective September 23, 2013.

Contact Information

If you have questions or need further assistance regarding this notice, you may contact: Health/Dental Plans Privacy Officer, c/o Human Resources Dept., Marmon Holdings, Inc., 181 West Madison St., 26th Floor, Chicago, IL 60602, 312-372-9500.

Note: The following terms as used in this section are defined in the Standards for Privacy of Individually Identifiable Health Information (45 CFR Parts 160 and 164): “protected health information,” “summary health information,” “business associates,” “personal representative,” “designated record set,” and “limited data set.”

GENERAL INFORMATION

PLAN NAME:

Marmon Healthcare Plan

TYPE OF PLAN AND ADMINISTRATION:

A welfare plan providing group medical and prescription drug benefits. The Plan is administered by a third-party Claim Administrator.

NAME AND ADDRESS OF PLAN SPONSOR:

Marmon Holdings, Inc.
181 W. Madison St.
Chicago, IL 60602
(312) 372-9500

A complete list of the Employers participating in the Plan may be obtained by covered persons upon written request to the Plan Administrator, and is available for examination by covered persons.

NAME AND ADDRESS OF THE PLAN ADMINISTRATOR:

The Marmon Group LLC
181 W. Madison St.
Chicago, IL 60602
(312) 372-9500

NAME AND ADDRESS OF DESIGNATED AGENT FOR SERVICE OF LEGAL PROCESS:

The Marmon Group LLC
181 W. Madison St.
Chicago, IL 60602
(312) 372-9500

NAME AND ADDRESS OF THE THIRD PARTY CLAIM ADMINISTRATOR:

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

INTERNAL REVENUE SERVICE AND PLAN IDENTIFICATION NUMBER:

The corporate tax identification number assigned by the Internal Revenue Service to the Plan Sponsor is 36-3104690. The plan number is 501

PLAN YEAR:

For purposes of plan operations and accounting, the 12-month period beginning January 1 and ending, December 31.

METHOD OF FUNDING BENEFITS:

Health and pharmacy benefits are self-funded and are paid directly by the Plan Sponsor from its general assets. The Plan Sponsor may purchase excess risk insurance coverage which is intended to reimburse the Plan Sponsor for certain losses incurred and paid under the Plan by the Plan Sponsor. Such excess risk coverage, if any, is not part of the Plan.

SOURCE OF CONTRIBUTIONS:

Your contributions toward the cost of coverage under this Plan is determined by your Employer.

EFFECTIVE DATE:

This booklet reflects the provisions of Plan H as administered by Blue Cross and Blue Shield of Illinois as of January 1, 2015.

Aviso Importante:

Para obtener informacion o para someter una queja usted puede llamar al numero de telefono gratis de Blue Cross and Blue Shield of Illinois para informacion o para someter una queja al: 1-800-892-2803. Usted tambien puede escribir a Blue Cross and Blue Shield of Illinois al: P. O. Box 805107, Chicago, Illinois 60680-4112.