GROUP HEALTH PROGRAM BOOKLET

This Group Health Program Booklet describes the benefits offered under the Medical Program and Prescription Drug Program as of January 1, 2021. The Medical Program and Prescription Drug Program are part of the RR Donnelley Group Benefits Plan.

August 2021

RRD BENEFITS
HEALTH | WEALTH | LIFE

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INTRODUCTION

Several welfare benefit programs offered by R. R. Donnelley & Sons Company and its participating subsidiaries (collectively RRD or the Company), combined, make up the RR Donnelley Group Benefits Plan (Group Benefits Plan or Plan). Generally, each welfare benefit program (or in some cases, a portion of a program) under the Group Benefits Plan is described in a separate program booklet, and the common administrative provisions applicable to each of the welfare benefit programs are set forth in the *Plan Administration Information Booklet* (*Administration Booklet*). Together, each of the program booklets and the *Administration Booklet*, as well as any applicable certificates of insurance, Summaries of Material Modifications (SMMs), the Annual Enrollment materials, and other plan summaries, make up the complete Summary Plan Description (SPD) for the Group Benefits Plan. The Medical Program and the Prescription Drug Program are referred to collectively as the Group Health Program. The complete SPD for the Group Health Program includes this Group Health Program Booklet, the *Administration Booklet*, as well as any SMMs, the Annual Enrollment materials, and other plan summaries.

This Group Health Program Booklet describes the medical and prescription drug benefit coverage options under the Group Benefits Plan as of January 1, 2021.

If capitalized terms are used in this Group Health Program Booklet and are not defined in the sentence where first used, such terms are defined in the in the subsection titled **Medical Program Terms to Know** in the **How the Group Health Program Works** section or the section titled **Prescription Drug Terms to Know**.

As stated above, the term "Group Health Program" refers collectively to:

- The Medical Program administered by Blue Cross and Blue Shield of Illinois (BCBSIL)*; and
- The Prescription Drug Program administered by CVS Caremark (Caremark).

* **Note:** BCBSIL's administration is not specific to the State of Illinois. BCBSIL is a national claims administrator with a nationwide network of Providers.

The Group Health Program enables you to select the level of coverage and cost that best meet your and your family's needs. These options offer you and your eligible dependents coverage for a wide range of services, including preventive care, Physicians' services, hospitalization and surgery, as well as coverage for prescription drugs.

The Group Health Program offers the following of options for medical benefits (administered by BCBSIL), and the specific options available to you depend on your home ZIP code:

- HSA Value
- HSA Advantage
- Copay Value
- Copay Value Select
- Copay Advantage

By enrolling in one of the above options, you will automatically receive corresponding coverage under the Prescription Drug Program (administered by Caremark).

A Health Savings Account (HSA) and/or Health Care Flexible Spending Account (FSA) can help pay medical expenses you would otherwise have to pay from your own pocket. If you elect the Copay Value, Copay Value Select or Copay Advantage option, you have access to a regular, full-use Health Care FSA. If you elect the HSA Value or HSA Advantage option, you have access to an HSA, as well as a limited-use Health Care FSA that you can use only for dental and vision expenses **before** your Deductible under the Medical Program has been met, and for qualified medical and prescription drug expenses **after** you have met your Deductible. For more information about the HSA and Health Care FSA, see the Flexible Benefits Program Booklet.

If you are a global transferee, the Group Benefits Plan offers international benefits, some of which are separate from the Group Health Program.

RRD and you each pay a portion of the cost for the Group Health Program's premium for you and your enrolled eligible dependents. Your cost is based on the option and coverage category you elect, so it is important that you know how the Group Health Program works. To view the premiums for each option available to you, go to **rrd.bswift.com**.

Note: Although you must pay the premium for the coverage you elect for you and your enrolled eligible dependents as outlined in your enrollment materials, RRD pays the majority of the total cost of coverage.

Alternatively, you may decide to purchase a private medical insurance policy instead of Group Health Program coverage; in that case, you will not receive any subsidy from RRD.

Please review this Group Health Program Booklet, including the documents linked at the end, to become an informed consumer of services, so you can make the best coverage decisions for you and your family. Please also review the *Administration Booklet* to become familiar with the applicable eligibility requirements, how to enroll in the Group Health Program, a description of your continuation of coverage rights, the applicable claims and appeals procedures, a description of how the Group Benefits Plan is administered, and an explanation of your ERISA rights. The Group Health Program has elected Utah to be its benchmark plan under the Affordable Care Act.

Group Health Program Summary Plan Description (SPD)

Together, this Group Health Program Booklet, the ***Administrative Booklet***, any SMMs, the Annual Enrollment materials, and other plan summaries make up the complete SPD for the Group Health Program under the Group Benefits Plan. Please read this information to familiarize yourself with your coverage. If changes to the Group Health Program occur, you will be notified through a SMM or the Annual Enrollment materials.

This Group Health Program Booklet (along with any SMMs and Annual Enrollment materials) is intended to be a complete, accurate and up-to-date description of your coverage options and available benefits under the Group Health Program. However, since treatments, protocols and practices continually change, this document cannot adequately define every potentially covered service or exclusion. In each case, the claims administrator or network manager will have the authority or discretion to make the determination of whether an expense incurred is a Covered Expense. If there is any discrepancy between the SPD and the Group Benefits Plan document, the Group Benefits Plan document always governs.

Union employees covered by a collective bargaining agreement need to refer to such agreement for any differences from the options offered as described in this Group Health Program Booklet. If there are conflicts between the rules contained in the SPD and the rules contained in your applicable collective bargaining agreement, your collective bargaining agreement will control.

Nothing in this Group Health Program Booklet should be interpreted as an employment contract. This Group Health Program Booklet merely describes the medical and prescription drug coverage and benefits offered to eligible employees as of January 1, 2021. RRD reserves the right to amend, change or terminate the Group Benefits Plan or Group Health Program, in whole or in part, at any time. Group Benefits Plan benefits do not vest.

This Group Health Program Booklet contains a summary in English of the benefits available under the Group Health Program. If you have difficulty understanding any part of this Group Health Program Booklet or the SPD, or to request language assistance call the RRD Benefits Center at **1-877-RRD-4BEN (1-877-773-4236)** or go to **rrd.bswift.com**. Benefits Center Representatives are available to assist you from 7 a.m. to 7 p.m. CT, Monday through Friday.

BENEFITS-AT-A-GLANCE

The chart below highlights some of the key features of each of the Group Health Program options. Under the HSA Value, HSA Advantage, Copay Value, Copay Value Select, and Copay Advantage options, you have the flexibility to use any Provider you want at any time, but you pay more for your covered services if they are performed by Non-Participating Providers.

<table>
<tr><th>HSA Value</th><th>HSA Advantage</th><th>Copay Value</th><th>Copay Advantage</th><th>Copay Value Select</th></tr>
<tr><td colspan="4">The Program pays a higher level of benefit when you receive in-network care.</td><td>The Program is similar to Copay Value, but it pays a higher level of benefit, has lower premiums, Deductibles, and Copays, as well as better Coinsurance. You must use Participating Providers and out of network care is only covered in an Emergency.</td></tr>
<tr><td colspan="2">You are responsible for paying Coinsurance after you have met the Deductible requirement.</td><td colspan="3">You are responsible for paying a Copay for certain services, and Coinsurance for other services after you have met the Deductible requirement.</td></tr>
<tr><td colspan="5">Participating Providers agree to a reimbursement schedule that is lower than the Maximum Reimbursable Expense. As a result, they cannot bill you for the difference between their billed expense and their reimbursement.</td></tr>
</table>

Summary Charts of the Coverage Options

The charts that follow summarize coverage under the HSA Value, HSA Advantage, Copay Value, Copay Value Select, and Copay Advantage options.

HSA Value

HSA Value Key Features	In-Network	Out-of-Network*
Annual Deductible • You Only • All other coverage categories (You + Spouse/Domestic Partner, You + Child(ren), You + Family) • Embedded individual Deductible (the most any covered individual pays in Deductible)	**You Pay** $4,100 $8,200 $6,900	
Annual Out-of-Pocket Maximum (includes Deductible) • You Only • All other coverage categories (You + Spouse/Domestic Partner, You + Child(ren), You + Family) • Embedded individual OOP Maximum	**You Pay** $6,900 $13,800 $6,900	
Prior Authorization	See **Preauthorization** for details	
Coinsurance	**Medical Program Pays**	
Physician Office Visits	75% after Deductible Virtual Visits: You pay $44/visit; Medical Program pays 75% Coinsurance after Deductible	50% after Deductible
Annual Physical Exam	100% no Deductible	50% after Deductible
Immunizations (children and adults)	100% no Deductible	50% after Deductible

HSA Value Key Features	In-Network	Out-of-Network*
Preventive Care Includes: • All evidence-based supplies or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force (USPSTF). • Routine immunizations, as recommended by the ACIP of the Centers of Disease Control and Prevention. • Evidence-informed Routine Preventive Care and screenings as provided by the Health Resources Services Administration (HRSA) for infants, children, adolescents and adult women, unless included in the USPSTF recommendations. • COVID-19 testing and vaccinations.	100% no Deductible	50% after Deductible
Independent X-ray and Lab Facility**	75% after Deductible	50% after Deductible
Inpatient/Outpatient Hospital Facility Services Inpatient subject to Preauthorization of Medical Necessity/covered service	75% after Deductible	50% after Deductible
Outpatient Surgery	75% after Deductible	50% after Deductible
Inpatient/Outpatient Professional Services (non-Emergency/Urgent Care)	75% after Deductible	50% after Deductible
Emergency/Urgent Care Facility (facility and professional services)	75% after Deductible	If BCBSIL determines: • True Emergency: 75% after Deductible • **Not** a true Emergency: 50% after Deductible
Outpatient Rehabilitation Services Includes speech, occupational, physical, pulmonary, cognitive and ABA therapy; limited to 90 visits per calendar year, in- and out-of-network combined	75% after Deductible	50% after Deductible
Outpatient Cardiac Rehabilitation Services Phases I and II Limited to 36 visits per calendar year, in-and out-of-network combined	75% after Deductible	50% after Deductible

HSA Value Key Features	In-Network	Out-of-Network*
Chiropractic Therapy Limited to 20 visits per calendar year, in-and out-of-network combined	75% after Deductible	50% after Deductible
Inpatient Skilled Nursing/Rehabilitation Subject to Preauthorization of Medical Necessity/covered service; limited to 90 days Inpatient or 90 visits for outpatient rehabilitation per calendar year, in- and out-of-network combined	75% after Deductible	50% after Deductible
Home Health Care Subject to Preauthorization of Medical Necessity; limited to 120 visits per calendar year, in- and out-of-network combined	75% after Deductible	50% after Deductible
Durable Medical Equipment	75% after Deductible	50% after Deductible
Inpatient Mental Health and Substance Abuse Subject to Preauthorization of Medical Necessity/covered service	75% after Deductible	50% after Deductible
Outpatient Mental Health and Substance Abuse	75% after Deductible	50% after Deductible
Prescription Drug Program	See the **Prescription Drug Program** chart for details	
Pregnancy	Covered under the same rules that apply to Physician office visits/and Inpatient/outpatient hospital visits (as applicable)	

* Expenses above the amounts recognized as Covered Expenses are your responsibility. These amounts do not count toward the Deductible or the Out-of-Pocket Maximum.

** If laboratory work and/or x-rays are done in an independent facility, claims will be processed at the applicable Coinsurance levels.

HSA Advantage

HSA Advantage Key Features	In-Network	Out-of-Network*
Annual Deductible • You Only • All other coverage categories (You + Spouse/Domestic Partner, You + Child(ren), You + Family)	**You Pay** $3,200 $6,400	
Annual Out-of-Pocket Maximum (includes Deductible) • You Only • All other coverage categories (You + Spouse/Domestic Partner, You + Child(ren), You + Family) • Embedded individual OOP Maximum	**You Pay** $6,900 $13,800 $6,900	
Prior Authorization	See **Preauthorization** for details	
Coinsurance	**Medical Program Pays**	
Physician Office Visits	80% after Deductible Virtual Visits: You pay $44/visit; Medical Program pays 80% after Deductible	40% after Deductible
Annual Physical Exam	100% no Deductible	40% after Deductible
Immunizations (children and adults)	100% no Deductible	40% after Deductible
Preventive Care Includes: • All evidence-based supplies or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force (USPSTF). • Routine immunizations, as recommended by the ACIP of the Centers of Disease Control and Prevention. • Evidence-informed Routine Preventive Care and screenings as provided by the Health Resources Services Administration (HRSA) for infants, children, adolescents and adult women, unless included in the USPSTF recommendations. • COVID-19 testing and vaccinations.	100% no Deductible	40% after Deductible
Independent X-ray and Lab Facility**	80% after Deductible	40% after Deductible

HSA Advantage Key Features	In-Network	Out-of-Network*
Inpatient/Outpatient Hospital Facility Services Inpatient subject to Preauthorization of Medical Necessity/covered service	80% after Deductible	40% after Deductible
Outpatient Surgery	80% after Deductible	40% after Deductible
Inpatient/Outpatient Professional Services (non-Emergency/Urgent Care)	80% after Deductible	40% after Deductible
Emergency/Urgent Care Facility (facility and professional services)	80% after Deductible	If BCBSIL determines: • True Emergency: 80% after Deductible • **Not** a true Emergency: 60% after Deductible
Outpatient Rehabilitation Services Includes speech, occupational, physical, pulmonary, cognitive and ABA therapy; limited to 90 visits per calendar year, in- and out-of-network combined	80% after Deductible	40% after Deductible
Outpatient Cardiac Rehabilitation Services Phases I and II Limited to 36 visits per calendar year, in-and out-of-network combined	80% after Deductible	40% after Deductible
Chiropractic Therapy Limited to 20 visits per calendar year, in-and out-of-network combined	80% after Deductible	40% after Deductible
Inpatient Skilled Nursing/Rehabilitation Subject to Preauthorization of Medical Necessity/covered service; limited to 90 days per calendar year, in- and out-of-network combined	80% after Deductible	40% after Deductible
Home Health Care Subject to Preauthorization of Medical Necessity; limited to 120 visits per calendar year, in- and out-of-network combined	80% after Deductible	40% after Deductible
Durable Medical Equipment/ External Prosthetic Appliances	80% after Deductible	40% after Deductible
Inpatient Mental Health and Substance Abuse Inpatient subject to Preauthorization of Medical Necessity/covered service	80% after Deductible	40% after Deductible

HSA Advantage Key Features	In-Network	Out-of-Network*
Outpatient Mental Health and Substance Abuse	80% after Deductible	40% after Deductible
Prescription Drug Program	See the **Prescription Drug Program** chart for details	
Pregnancy	Covered under the same rules that apply to Physician office visits/and Inpatient/outpatient hospital visits (as applicable)	

* Expenses above the amounts recognized as Covered Expenses are your responsibility. These amounts do not count toward the Deductible or the Out-of-Pocket Maximum.

** If laboratory work and/or x-rays are done in an independent facility, claims will be processed at the applicable Coinsurance levels.

Copay Value

Copay Value Key Features	In-Network	Out-of-Network*
Annual Deductible • You Only • All other coverage categories (You + Spouse/Domestic Partner, You + Child(ren), You + Family) • Embedded individual Deductible	**You Pay** $4,100 $8,200 $6,900	
Annual Out-of-Pocket Maximum (includes Deductible) • You Only • All other coverage categories (You + Spouse/Domestic Partner, You + Child(ren), You + Family) • Embedded individual OOP Maximum	**You Pay** $6,900 $13,800 $6,900	
Prior Authorization	See **Preauthorization** for details	
Copay/Coinsurance	**Medical Program Pays**	
Physician Office Visits	You pay Copay: $25 for PCP and Mental Health, $50 for Specialists** Virtual Visits: $25/visit no Deductible	50% after Deductible
Annual Physical Exam	100% no Deductible	50% after Deductible
Immunizations (children and adults)	100% no Deductible	50% after Deductible

Copay Value Key Features	In-Network	Out-of-Network*
Preventive Care Includes: • All evidence-based supplies or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force (USPSTF). • Routine immunizations, as recommended by the ACIP of the Centers of Disease Control and Prevention. • Evidence-informed Routine Preventive Care and screenings as provided by the Health Resources Services Administration (HRSA) for infants, children, adolescents and adult women, unless included in the USPSTF recommendations. • COVID-19 testing and vaccinations.	100% no Deductible	50% after Deductible
Independent X-ray and Lab Facility**	75% after Deductible	50% after Deductible
Inpatient/Outpatient Hospital Facility Services Inpatient subject to Preauthorization of Medical Necessity/covered service	75% after Deductible	50% after Deductible
Outpatient Surgery	75% after Deductible	50% after Deductible
Inpatient/Outpatient Professional Services (non-Emergency/Urgent Care)	75% after Deductible	50% after Deductible
Emergency (Emergency/Urgent Care)	You pay $600 Copay, Medical Program pays 75% no Deductible	You pay $600 Copay, Medical Program pays – if BCBSIL determines: • True Emergency: 75% no Deductible • **Not** a true Emergency: 50% no Deductible
Outpatient Rehabilitation Services Includes speech, occupational, physical, pulmonary, cognitive and ABA therapy; limited to 90 visits per calendar year, in- and out-of-network combined	You pay $50 copay/visit; no Deductible	50% after Deductible

Copay Value Key Features	In-Network	Out-of-Network*
Outpatient Cardiac Rehabilitation Services Phases I and II Limited to 36 visits per calendar year, in- and out-of-network combined	75% after Deductible	50% after Deductible
Chiropractic Therapy Limited to 20 visits per calendar year, in- and out-of-network combined	75% after Deductible	50% after Deductible
Inpatient Skilled Nursing/ Rehabilitation Subject to Preauthorization of Medical Necessity/covered service; limited to 90 days per calendar year, in- and out-of-network combined	75% after Deductible	50% after Deductible
Home Health Care Subject to Preauthorization of Medical Necessity; limited to 120 visits per calendar year, in- and out-of-network combined	75% after Deductible	50% after Deductible
Durable Medical Equipment/ External Prosthetic Appliances	75% after Deductible	50% after Deductible
Inpatient Mental Health and Substance Abuse Inpatient subject to Preauthorization of Medical Necessity/covered service	75% after Deductible	50% after Deductible
Outpatient Mental Health and Substance Abuse	75% after Deductible	50% after Deductible
Prescription Drug Program	See the **Prescription Drug Program** chart for details	
Pregnancy	Covered under the same rules that apply to Physician office visits/and Inpatient/outpatient hospital visits (as applicable)	

* Expenses above the amounts recognized as Covered Expenses are your responsibility. These amounts do not count toward the Deductible or the Out-of-Pocket Maximum.

** If laboratory work and/or x-rays are done in an independent facility, claims will be processed at the applicable Coinsurance levels.

Copay Value Select

Copay Value Select Key Features	In-Network Only
Annual Deductible • You Only • All other coverage categories (You + Spouse/Domestic Partner, You + Child(ren), You + Family)	**You Pay** $3,600 $7,200
Annual Out-of-Pocket Maximum (includes Deductible) • You Only • All other coverage categories (You + Spouse/Domestic Partner, You + Child(ren), You + Family) • Embedded individual OOP Maximum	**You Pay** $6,900 $13,800 $6,900
Prior Authorization	See **Preauthorization** for details
Copay/Coinsurance	**Medical Program Pays**
Physician Office Visits	You pay Copay: $15 for PCP or Mental Health, $30 for Specialists no Deductible Virtual Visits: $15/visit no Deductible
Annual Physical Exam	100% no Deductible
Immunizations (children and adults)	100% no Deductible
Preventive Care Includes: • All evidence-based supplies or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force (USPSTF). • Routine immunizations, as recommended by the ACIP of the Centers of Disease Control and Prevention. • Evidence-informed Routine Preventive Care and screenings as provided by the Health Resources Services Administration (HRSA) for infants, children, adolescents and adult women, unless included in the USPSTF recommendations. • COVID-19 testing and vaccinations.	100% no Deductible

Copay Value Select Key Features	In-Network Only
Independent X-ray and Lab Facility**	80% after Deductible
Inpatient/Outpatient Hospital Facility Services Inpatient subject to Preauthorization of Medical Necessity/covered service	80% after Deductible
Outpatient Surgery	80% after Deductible
Inpatient/Outpatient Professional Services	80% after Deductible
Emergency (facility and professional services) Emergency medical transportation	You pay $600 Copay (includes services rendered at an out-of-network facility in an Emergency) Medical Program pays 80% after Deductible
Outpatient Rehabilitation Services Includes speech, occupational, physical, pulmonary, cognitive and ABA therapy; limited to 90 visits per calendar year; Preauthorization may be required	You pay $30 Copay/visit no Deductible Medical Program pays 80% after Deductible for other services
Outpatient Cardiac Rehabilitation Services Phases I and II Limited to 36 visits per calendar year	80% after Deductible
Chiropractic Therapy Limited to 20 visits per calendar year	80% after Deductible
Inpatient Skilled Nursing/ Rehabilitation Subject to Preauthorization of Medical Necessity/covered service; limited to 90 days per calendar year	80% after Deductible
Home Health Care Subject to Preauthorization of Medical Necessity; limited to 120 visits per calendar year	80% after Deductible
Durable Medical Equipment/ External Prosthetic Appliances	80% after Deductible
Inpatient Mental Health and Substance Abuse Inpatient subject to Preauthorization of Medical Necessity/covered service	80% after Deductible

Copay Value Select Key Features	In-Network Only
Outpatient Mental Health and Substance Abuse	80% after Deductible
Prescription Drug Program	See the **Prescription Drug Program** chart for details
Pregnancy	Covered under the same rules that apply to Physician office visits/and Inpatient/outpatient hospital visits (as applicable)

* Expenses above the amounts recognized as Covered Expenses are your responsibility. These amounts do not count toward the Deductible or the Out-of-Pocket Maximum.

** If laboratory work and/or x-rays are done in an independent facility, claims will be processed at the applicable Coinsurance levels.

Copay Advantage

Copay Advantage Key Features	In-Network	Out-of-Network*
Annual Deductible • You Only • All other coverage categories (You + Spouse/Domestic Partner, You + Child(ren), You + Family)	**You Pay** $3,200 $6,400	
Annual Out-of-Pocket Maximum (includes Deductible) • You Only • All other coverage categories (You + Spouse/Domestic Partner, You + Child(ren), You + Family) • Embedded individual OOP Maximum	**You Pay** $6,900 $13,800 $6,900	
Prior Authorization	See **Preauthorization** for details	
Copay/Coinsurance	**Medical Program Pays**	
Physician Office Visits	You pay Copay: $25 for PCP or Mental Health, $40 for Specialists	60% after Deductible
Annual Physical Exam	100% no Deductible	60% after Deductible
Immunizations (children and adults)	100% no Deductible	60% after Deductible
Preventive Care Includes: • All evidence-based supplies or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force (USPSTF). • Routine immunizations, as recommended by the ACIP of the Centers of Disease Control and Prevention. • Evidence-informed Routine Preventive Care and screenings as provided by the Health Resources Services Administration (HRSA) for infants, children, adolescents and adult women, unless included in the USPSTF recommendations. • COVID-19 testing and vaccinations.	100% no Deductible	60% after Deductible

Copay Advantage Key Features	In-Network	Out-of-Network*
Independent X-ray and Lab Facility**	80% after Deductible	60% after Deductible
Inpatient/Outpatient Hospital Facility Services Inpatient subject to Preauthorization of Medical Necessity/covered service	80% after Deductible	60% after Deductible
Outpatient Surgery	80% after Deductible	60% after Deductible
Inpatient/Outpatient Professional Services	80% after Deductible	60% after Deductible
Emergency (facility and professional services)	You pay $500 Copay, Medical Program pays 80% no Deductible	You pay $500 Copay, Medical Program pays if BCBSIL determines: • True Emergency: 80% no Deductible • **Not** a true Emergency: 60% after Deductible
Outpatient Rehabilitation Services Includes speech, occupational, physical, pulmonary, cognitive and ABA therapy; limited to 90 visits per calendar year, in- and out-of-network combined	You pay $40 Copay/visit no Deductible	60% after Deductible
Outpatient Cardiac Rehabilitation Services Phases I and II Limited to 36 visits per calendar year, in- and out-of-network combined	80% after Deductible	60% after Deductible
Chiropractic Therapy Limited to 20 visits per calendar year, in- and out-of-network combined	80% after Deductible	60% after Deductible
Inpatient Skilled Nursing/ Rehabilitation Subject to Preauthorization of Medical Necessity/covered service; limited to 90 days per calendar year, in- and out-of-network combined	80% after Deductible	60% after Deductible
Home Health Care Subject to Preauthorization of Medical Necessity; limited to 120 visits per calendar year, in- and out-of-network combined	80% after Deductible	60% after Deductible
Durable Medical Equipment/ External Prosthetic Appliances	80% after Deductible	60% after Deductible

Copay Advantage Key Features	In-Network	Out-of-Network*
Inpatient Mental Health and Substance Abuse Inpatient subject to Preauthorization of Medical Necessity/covered service	80% after Deductible	60% after Deductible
Outpatient Mental Health and Substance Abuse	80% after Deductible	60% after Deductible
Prescription Drug Program	See the **Prescription Drug Program** chart for details	
Pregnancy	Covered under the same rules that apply to Physician office visits/and Inpatient/outpatient hospital visits (as applicable)	

* Expenses above the amounts recognized as Covered Expenses are your responsibility. These amounts do not count toward the Deductible or the Out-of-Pocket Maximum.

** If laboratory work and/or x-rays are done in an independent facility, claims will be processed at the applicable Coinsurance levels.

Prescription Drug Program

Your prescription drug coverage is dependent upon the option you elect under the Medical Program. You pay the amounts and percentages shown and the Prescription Drug Program pays the rest. Here is a summary of the prescription drug coverage under each option:

Prescription Drug Program	You Pay In-Network Retail Store (up to 30-day supply)	You Pay In-Network Mail Order (up to 90-day supply)
Prior Authorization	See **Prior Authorization** for details	
Diabetes Supplies and Insulin	0%	0%
Generic Preventive Medicine for Hypertension and Hyperlipidemia*	0%	0%
HSA Value**		
Generic	25% after Deductible	
Brand Formulary	40% after Deductible	
Brand Non-Formulary	50% after Deductible	
Specialty	50% after Deductible	
HSA Advantage**		
Generic	20% after Deductible	
Brand Formulary	30% after Deductible	
Brand Non-Formulary	40% after Deductible	
Specialty	40% after Deductible	
Copay Value***		
Generic	25%; Min $10 – Max $45	25%; Min $25 – Max $115
Brand Formulary	40%; Min $40 – Max $100	40%; Min $100 – Max $250
Brand Non-Formulary	50%; Min $75 – Max $150	50%; Min $185 – Max $375
Specialty	$210	More than 30-day supply not allowed

Prescription Drug Program	You Pay In-Network Retail Store (up to 30-day supply)	You Pay In-Network Mail Order (up to 90-day supply)
Copay Value Select* **		
Generic	25%; Min $10 – Max $45	25%; Min $25 – Max $115
Brand Formulary	40%; Min $40 – Max $100	40%; Min $100 – Max $250
Brand Non-Formulary	50%; Min $75 – Max $150	50%; Min $185 – Max $375
Specialty	$210	Mail Order not allowed
Copay Advantage* **		
Generic	20%; Min $10 – Max $40	20%; Min $25 – Max $100
Brand Formulary	30%; Min $40 – Max $75	30%; Min $100 – Max $185
Brand Non-Formulary	40%; Min $55 – Max $125	40%; Min $140 – Max $315
Specialty	$150	More than 30-day supply not allowed

* If you participate in the HSA Value or HSA Advantage options, you may be required to meet the Deductible before 0% cost-sharing begins, unless the particular medication prescribed satisfies the IRS criteria to be considered "preventive." If you have been diagnosed with a chronic condition specified in IRS guidance, and the medication is prescribed for the purpose of preventing the exacerbation of the chronic condition or the development of a secondary condition, the Deductible may be waived if permitted by the IRS guidance.

** HSA Value and HSA Advantage are subject to the applicable Medical Program option's Deductible before Coinsurance begins.

*** If the total cost of the prescription is less than the minimum Coinsurance dollar amount specified, you are only responsible for the total cost of the prescription.

HOW THE GROUP HEALTH PROGRAM WORKS

When you are hired, or during the communicated Annual Enrollment period, you can enroll yourself and your eligible dependents in the Group Health Program, which includes the Medical Program (administered by BCBSIL) and the Prescription Drug Program (administered by Caremark). The Group Health Program offers a variety of options for medical benefits (the specific options available to you depend on your ZIP code), including the following (administered by BCBSIL):

- HSA Value
- HSA Advantage
- Copay Value
- Copay Value Select
- Copay Advantage

By enrolling in one of the above options, you will receive coverage under the corresponding option offered under the Prescription Drug Program (administered by Caremark).

Home ZIP Code Determines Enrollment Offerings

Your home ZIP code determines which options are offered to you when you are hired and during each Annual Enrollment period. If it is determined you have insufficient Participating Provider representation within BCBSIL's network, then that particular option is **not** included as an offering to you.

Enrollment is valid for the balance of the calendar year and cannot be changed until the next Annual Enrollment period, unless you have and report a Qualified Status Change or a special enrollment opportunity.

When you or your covered dependents incur an expense, the Group Health Program will pay that portion of the expense that you are not responsible to pay, but only if it is a Covered Expense (defined below in the subsection titled in **Medical Program Terms to Know**).

You (or your covered dependent who incurred the expense) are responsible for paying:

- Any amount that is not considered part of the Covered Expense (for example, expenses that are not covered by the Group Health Program)
- Your **Deductible** for the calendar year
- Any amount over the **Maximum Reimbursable Expense** for out-of-network services
- Your **Coinsurance**, up to your annual **Out-of-Pocket Maximum**

WHAT'S COVERED

The following are examples of expenses that may qualify as a Covered Expense under the Medical Program options administered by BCBSIL.

Preventive Care

The Medical Program (regardless of which option you elect) covers all preventive care services required by the Affordable Care Act:

- Evidence-based supplies or services that have in effect a rating of "A" or "B" in the current recommendations of the USPSTF. The complete list of the current USPSTF recommendations with an A or B rating is available at: **USPSTF Recommendations**.
- Routine immunizations, as recommended by the ACIP of the Centers of Disease Control and Prevention.
- Evidence-informed Routine Preventive Care and screenings as provided by the Health Resources Services Administration (HRSA) for infants, children, adolescents and adult women, unless included in the USPSTF recommendations.

The Medical Program also covers COVID-19 testing and vaccinations as required by law.

For more information, see **https://www.healthcare.gov/coverage/preventive-care-benefits/**.

Adults

The following is a summary of key preventive care benefits provided for adults:

- Abdominal aortic aneurysm one-time screening for men aged 65 to 75 years who have ever smoked.
- Abnormal blood glucose and Type 2 Diabetes Mellitus screening for adults aged 40 to 70 years who are overweight or obese.
- Alcohol misuse screening and counseling.
- Aspirin use to prevent cardiovascular disease and colorectal cancer for adults 50 to 59 with a high cardiovascular risk.
- Behavioral counseling interventions to promote a healthy diet and physical activity for adults with cardiovascular disease risk factors.
- Blood pressure screening.
- Cholesterol screening for adults of certain ages or at higher risk.
- Colorectal cancer screening (i.e., colonoscopies, including pre-procedure consultation, bowel preparation kits and pathology exam) for adults 50 to 75.
- COVID-19 testing and vaccinations.
- Depression screening.
- Diabetes (Type 2) screening for adults 40 to 70 years who are overweight or obese.
- Diet counseling for adults at higher risk for chronic disease.
- Drug use screening.

- Falls prevention (with exercise or physical therapy and vitamin D use) for adults 65 years and over, living in a community setting.
- Hepatitis B screening for people at high risk.
- Hepatitis C screening for adults at increased risk, and one time for everyone born 1945–1965.
- HIV screening for everyone ages 15 to 65, and other ages at increased risk.
- Immunization vaccines (see Immunizations below).
- Lung cancer screening for adults 55 to 80 at high risk.
- Obesity screening and counseling.
- Preexposure prophylaxis (PrEP) with effective antiretroviral therapy to persons who are at high risk of HIV acquisition.
- Sexually transmitted infection (STI) preventing counseling for higher-risk individuals.
- Skin cancer prevention counseling for young adults about minimizing exposure to ultraviolet (UV) radiation for persons up to 24 years with fair skin types to reduce their risk of skin cancer.
- Statin preventive medication for adults 40 to 75 at high risk.
- Syphilis screening for higher-risk individuals.
- Tobacco use screening for all adults, and, for tobacco users, two (2) tobacco cessation attempts per year and tobacco cessation medications for a ninety (90) day treatment regimen when prescribed by a Physician.
- Tuberculosis screening for certain high-risk individuals.

BCBSIL will apply reasonable medical management techniques to determine the appropriate frequency, method, treatment, or setting for a preventive item or service to the extent that such techniques are not specified in the recommendations or guidelines. For more information, see their Adult Wellness Guidelines at **https://www.bcbsil.com/PDF/wellness-guidelines-adult-il.pdf**. You can also access the latest guidelines any time by logging in to Blue Access for Members℠ (BAM℠) at **https://www.bcbsil.com/member**. Click the My Health tab and scroll down to Wellness Guidelines.

The Medical Program will not provide coverage for the above referenced adult preventive services until the Plan Year that begins on or after one year after the date such recommendation or guideline referenced above is issued, unless an earlier date is specifically required by law.

Women

The following is a summary of key preventive care benefits provided for women:

- Breast cancer genetic testing (for BRCA 1 and 2) and counseling for women at higher risk (women with a personal or family history of breast, ovarian, tubal, or peritoneal cancer, or who have an ancestry associated with breast cancer susceptibility 1 and 2 (BRCA1/2) gene mutations).
- Breast cancer mammography screenings every 1 to 2 years for women over 40.
- Breast cancer chemoprevention (medications such as such as tamoxifen, raloxifene, or aromatase inhibitors) and counseling for women at higher risk age 35 and older.

- Cervical cancer screening - Pap test (also called a Pap smear) every 3 years for women 21 to 65; Human Papillomavirus (HPV) DNA test with the combination of a Pap smear every 5 years for women 30 to 65 who don't want a Pap smear every 3 years.
- Human Papillomavirus (HPV) DNA test no more frequently than every three (3) years for a woman age 30 and above.
- Chlamydia infection screening for women age 24 and younger and other women at higher risk.
- Diabetes screening for women as indicated.
- Domestic and interpersonal violence screening and counseling (annual) for all women.
- Gonorrhea screening for women age 24 and younger and other women at higher risk.
- HIV screening and counseling (annual) for sexually active women.
- Osteoporosis screening for women over age 60 depending on risk factors.
- Sexually transmitted infections (STI) counseling (annual) for sexually active women.
- Syphilis screening for women at increased risk.
- Tobacco use screening and behavioral interventions.
- Urinary incontinence screening for women yearly.
- Well-woman visits (annual) to get recommended services for women under 65.

The following is a summary of additional services for pregnant women or women who may become pregnant:

- Anemia screening.
- Asymptomatic Bacteriuria screening in pregnant women.
- Breastfeeding support and counseling from trained Providers, and access to breastfeeding supplies (includes the cost of purchase or rental, whichever is less costly), for pregnant and nursing women.
- Contraception: Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling, as prescribed by a health care Provider for women with reproductive capacity (not including abortifacient drugs).
- Depression screening and counseling interventions for pregnant and post-partum women.
- Folic acid supplements for women who may become pregnant.
- Gestational diabetes screening for women after 24 weeks of pregnancy and those at high risk.
- Gonorrhea screening for all women at higher risk.
- Hepatitis B screening for pregnant women at their first prenatal visit.
- Low dose aspirin as preventive medication after 12 weeks of gestation in women who are at high risk for preeclampsia.
- Preeclampsia prevention and screening for pregnant women with high blood pressure.
- Rh incompatibility screening for all pregnant women and follow-up testing for women at higher risk.
- Syphilis screening.
- Expanded tobacco intervention and counseling for pregnant tobacco users.

- Urinary tract or other infection screening.

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

The Medical Program will not provide coverage for the above referenced women's preventive services until the Plan Year that begins on or after one year after the date such recommendation or guideline referenced above is issued, unless an earlier date is specifically required by law.

Children and Adolescents

The following is a summary of key preventive care benefits provided for children and adolescents:

- Alcohol, tobacco, and drug use assessments for adolescents.
- Autism screening for children at 18 and 24 months.
- Behavioral assessments for children ages at regular intervals.
- Bilirubin concentration screening for newborns.
- Blood screening for newborns.
- Blood pressure screening for children ages at regular intervals.
- Cervical dysplasia screening for sexually active females.
- COVID-19 testing and vaccinations.
- Depression screening for adolescents beginning routinely at age 12.
- Developmental screening for children under age 3.
- Dyslipidemia screening.
- Fluoride chemoprevention supplements for children as indicated.
- Fluoride varnish for all infants and children as soon as teeth are present.
- Gonorrhea preventive medication for the eyes of all newborns.
- Hearing screening for all children (and newborns) as indicated.
- Height, weight and body mass index (BMI) measurements for children at regular intervals.
- Hematocrit or hemoglobin screening for all children.
- Hemoglobinopathies or sickle cell screening for newborns.
- Hepatitis B screening for adolescents at high risk.
- HIV screening for adolescents at higher risk.
- Hypothyroidism screening for newborns.
- Immunization vaccines (see Immunizations below).
- Iron supplements for children ages 6 to 12 months at risk for anemia.
- Lead screening for children at risk of exposure.
- Maternal depression screening for mothers of infants at 1, 2, 4, and 6-month visits.
- Medical history for all children at regular intervals.

- Obesity screening and counseling; intensive behavioral interventions in children ages 6 and older.
- Oral health risk assessment for young children at regular intervals.
- Phenylketonuria screening for newborns.
- Sexually transmitted infection (STI) prevention counseling and screening for adolescents at higher risk.
- Skin cancer prevention counseling for adolescents, children, and parents of young children about minimizing exposure to ultraviolet (UV) radiation for persons aged 6 months and older with fair skin types to reduce their risk of skin cancer.
- Tobacco interventions, including education or brief counseling, to prevent initiation of tobacco use among school-aged children and adolescents.
- Tuberculin testing for children at higher risk as indicated.
- Vision screening for all children.

BCBSIL will apply reasonable medical management techniques to determine the appropriate frequency, method, treatment, or setting for a preventive item or service to the extent that such techniques are not specified in the recommendations or guidelines. For more information, see their Children's Wellness Guidelines at **https://www.bcbsil.com/PDF/wellness-guidelines-child-il.pdf**. You can also access the latest guidelines any time by logging in to Blue Access for Members℠ (BAM℠) at **https://www.bcbsil.com/member**. Click the My Health tab and scroll down to Wellness Guidelines.

The Medical Program will not provide coverage for the above referenced children's preventive services until the Plan Year that begins on or after one year after the date such recommendation or guideline referenced above is issued, unless an earlier date is specifically required by law.

Immunizations

The ACIP recommendations for immunizations vary depending on age and other factors. The current recommendations for adults (19 years or older) are available at **https://www.cdc.gov/vaccines/schedules/downloads/adult/adult-combined-schedule.pdf**.

In general, recommended immunizations for adults include (but are not limited to):

- COVID-19
- Diphtheria
- Hepatitis A
- Hepatitis B
- Herpes Zoster
- Human Papillomavirus (HPV)
- Influenza (flu shot)
- Measles
- Meningococcal
- Mumps
- Pertussis (Whooping Cough)

- Pneumococcal
- Rubella
- Tetanus
- Varicella (Chickenpox)

The current recommendations for children and adolescents (0-18 years) are available at: **https://www.cdc.gov/vaccines/schedules/downloads/child/0-18yrs-child-combined-schedule.pdf**.

In general, recommended immunizations for children include (but are not limited to):

- COVID-19 (when approved for use in children)
- Diphtheria, Tetanus, Pertussis (Whooping Cough)
- Haemophilus influenza type b
- Hepatitis A
- Hepatitis B
- Human Papillomavirus (HPV)
- Inactivated Poliovirus
- Influenza (flu shot)
- Measles
- Meningococcal
- Pneumococcal
- Rotavirus
- Varicella (Chickenpox)

Professional Services

ABA therapy – Applied Behavior Analysis and other Early Intensive Behavioral Intervention (EIBI) programs (examples of EIBI include, but are not limited to, Lovaas therapy, discrete trial training, LEAP (Learning Experiences and Alternative Programs), TEACCH (Treatment and Education of Autistic and Related Communication of Handicapped Children), the Denver program, the Rutgers program, etc.). You or an enrolled eligible dependent must meet claims administrator-specific criteria for the in-network therapy to be approved and covered by the Medical Program. Please work with BCBSIL to confirm the preapproval process and criteria surrounding coverage of ABA therapy.

Allergy treatment – services provided in a Physician's office for the diagnosis and treatment of allergies.

Bariatric surgery – you or an enrolled eligible dependent must meet claims administrator-specific criteria for the surgery to be approved and covered by the Medical Program. These criteria generally include, but are not limited to, a minimum BMI, Physician approval, unsuccessful attempts at weight loss via a Physician-supervised established weight-loss program(s), age and other health side effects. Please work with BCBSIL to confirm the preapproval process and criteria surrounding coverage of bariatric surgery.

Cognitive therapy – you or an enrolled eligible dependent must meet claims administrator-specific criteria for the in-network therapy to be approved and covered by the Medical Program. Please work with BCBSIL to confirm the preapproval process and criteria surrounding coverage of cognitive therapy.

Hearing aids – covered when a hearing aid is required for the correction of a hearing impairment (a reduction in the ability to perceive sound, which may range from slight to complete deafness) with the written recommendation by a Physician or Provider. Initial purchase is limited to $5,000 (including charges for associated fitting and testing). Replacement benefits are limited to $5,000 every 36 months.

Hearing exams – services provided to determine hearing status, as part of a PCP's or other Provider's exam, with the intent of determining the need for a hearing evaluation or hearing aid.

Inpatient Hospital professional services – services that are provided by an appropriately licensed Physician during a Hospital Confinement and in conjunction with an inpatient admission.

Multiple surgeries – surgical procedures during one operating session that are secondary or incidental to the primary surgery. The maximum amount the Medical Program pays is the amount otherwise payable for the most expensive procedure, and half of the amount otherwise payable for all other procedures. The Medical Program pays benefits for any charge that is made by an assistant or co-surgeon, up to 20% of the primary surgeon's allowable charge. (For purposes of this Covered Expense, "allowable charge" means the covered amount payable to the surgeon before any reductions due to Coinsurance or Deductible amounts.)

Outpatient professional services – services provided by an appropriately licensed Physician in conjunction with outpatient services that are provided at a Hospital or a licensed Outpatient Surgical Facility. Such services may include those services provided by a pathologist, radiologist, anesthesiologist, Emergency medicine Physician, oncologist or nephrologist. Includes inpatient facility and outpatient setting.

Physician office visits – services provided in a Physician's office, including routine preventive care and the diagnosis and treatment of an illness or injury. Such services also may include Emergency Care Services. Lab/x-rays that are sent to and billed by an independent lab/x-ray facility will be paid under the independent lab/x-ray facility benefit.

Preventive care – see the **Preventive Care** section for a description of covered services, such as routine immunizations for children, annual routine physicals to detect illness, well-woman exams and early cancer detection screenings. The components that make up a preventive care exam are determined by your age, gender and health status.

Women's breast health services – such services include all Medically Necessary services and supplies. In addition, the Medical Program also pays benefits for certain breast reconstruction services in connection with a mastectomy. This coverage includes:

- Reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prosthesis and physical complications for all stages of the mastectomy, including lymphedema; and
- Expenses for brassieres bought incidental to mastectomy or reconstructive breast surgery.

Infertility and Reproductive Services

Infertility testing – to diagnose infertility only.

Treatment performed in connection with an underlying medical condition that may restore fertility – may also be covered (e.g., endometriosis diagnosis, which can cause infertility, treatment of endometriosis may be covered). Treatment and/or procedures performed specifically to restore fertility (those directly related to the actual attempted or assisted impregnation or fertilization (including infertility medications) are not covered; refer to the subsection titled **What's Not Covered**).

Physician office visits and delivery – diagnostic services, prenatal and postnatal visits and delivery services. Such services may include those provided by a licensed and certified midwife who is working under the direct supervision of a Physician (as permitted by state law).

Surgical sterilization procedures for vasectomy/tubal ligations – sterilization surgeries for men or women.

Voluntary pregnancy termination – services provided by an appropriately licensed Physician to terminate a pregnancy.

Family planning – office visits – services for testing and counseling.

Home delivery services – provided in conjunction with the delivery of a child or children in the home setting. Such services must be provided by an appropriately licensed and certified midwife and must be provided under the direct supervision of a Physician who is acting within the scope of his or her license (as permitted by law).

Hospital facility or birthing center services –

- Expenses for Hospital Room and Board and ancillary supplies for the covered individual that would have been eligible had the Hospital Confinement been for a sickness or injury.
- Expenses for Hospital nursery or room accommodations for the newborn(s) during the period that both the mother and newborn child(ren) are Confined in a Hospital.
- Services for newborn child(ren) who remain in the Hospital after the mother is released, or services that start on the date the child(ren) requires special care (such as an incubator or medical treatment because of a diagnosed sickness or injury). Such services are considered a separate claim.

- Physician fees for prenatal care, for the delivery of the newborn child(ren), or for dilation and curettage (in the case of a miscarriage).
- Physician fees to administer an anesthetic.
- Physician fees for circumcision of a newborn child(ren).

Rights Under the Newborns' and Mothers' Health Protection Act

Under federal law, the Group Health Program generally may not 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 delivery by 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, the Group Health Program may not, under federal law, require that a Provider obtain authorization from the Group Health Program for prescribing a length of stay not in excess of 48 hours (or 96 hours). However, to use certain Providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain Preauthorization. For information on Preauthorization, contact BCBSIL.

Outpatient Hospital and Emergency Room

Emergency care, including Hospital Emergency room, outpatient facility or other Urgent Care facility – includes professional, technical and supply fees for facilities, and supplies used in conjunction with Emergency Care. The Medical Program covers Emergencies and Urgent Care services 24 hours a day, worldwide.

Outpatient preadmission testing – services provided for testing required before admission.

Outpatient surgical facility services – includes technical fees for facilities and supplies used in conjunction with an outpatient surgical procedure. The surgical procedure must be performed in an appropriately licensed surgical facility or Hospital.

Inpatient Hospital

Inpatient Hospital facility services –

- Hospital Room and Board for a semiprivate room, isolation unit or coronary care unit. Private room expenses are covered when Medically Necessary as determined by BCBSIL.
- Hospital services and supplies, including the use of an operating and recovery room, surgical dressings, x-rays, lab tests, drugs and medicines consumed during a Hospital Confinement; anesthetics and their administration; oxygen and its administration; and blood and blood plasma in excess of credits for blood replaced by individual blood donors. Private-duty Nursing services inside the Hospital are covered only as approved by BCBSIL.

Inpatient Surgery – all Medically Necessary, non-Experimental surgery and supplies.

Organ Transplants – all Medically Necessary, non-Experimental transplants, including cadaver or live donor match testing, and inpatient facility and Physician services. The Medical Program also pays benefits for immunosuppressive medication. Certain transplants are not covered based on the Office of Medical Applications of Research of the National Institutes of Health's ruling. Refer to section **What's Not Covered** and contact BCBSIL before you incur any related costs.

Organ Transplant Travel Benefits

You have access to a network of participating hospitals that provide organ transplant services. When you or an enrolled eligible dependent receives care through this network, you may be eligible for certain travel benefits related to the organ transplant. These benefits include up to $10,000 per transplant per lifetime for food, lodging and transportation for the patient and one companion. This amount is taxable to you under federal law.

Miscellaneous Services

Ambulance transport – appropriately licensed ambulance services to or from the nearest Hospital that can provide medical care and treatment when Medically Necessary. This includes air ambulance when Medically Necessary. BCBSIL determines if the air ambulance service qualifies as Medically Necessary.

Cardiac and pulmonary rehabilitation (Phases I and II) – includes inpatient and outpatient treatment. Phase I rehabilitation is covered in conjunction with an inpatient confinement. Phase II rehabilitation is covered on an ambulatory basis and is limited to 36 visits per calendar year.

Chiropractic therapy – limited to 20 visits per calendar year for Medically Necessary treatment of injury or illness.

Contact lenses and eyeglasses – limited to the first pair following cataract surgery, for the initial replacement of natural lenses. The Medical Program does not pay benefits for the purchase of contacts or eyeglasses, unless they are necessary to treat an illness or injury.

Dental care – limited to the treatment of a fractured jaw or the repair of an accidental injury to sound, natural teeth that is sustained while covered under the Medical Program. Treatment must begin and complete within a specific time period following the accident or injury (time requirement is found in the option you select). Expenses for appliances necessary to stabilize the joint and necessary surgery for treatment of temporomandibular joint (TMJ) dysfunction syndrome are covered. Hospital facility expenses and anesthesia may be covered subject to Medical Necessity. Services for orthognathic surgery may be covered subject to Medical Necessity or covered services.

Durable Medical Equipment – equipment that is provided for use in the home, including (but not limited to) external insulin pumps, oxygen and ostomy supplies. This also includes equipment rental expenses such as wheelchairs, hospital beds and any device that provides mechanical ventilator support.

External prosthetic appliances – any appliance that is provided to replace or substitute a missing body part, and that is necessary to alleviate or correct sickness, injury or a congenital defect. This includes the initial fitting and purchase of an external prosthetic device, including:

- Artificial lenses,
- Artificial limbs,
- Terminal devices (such as a hand or hook), and
- External breast prostheses.

The Medical Program pays benefits for the replacement only if it is needed due to normal body growth. The Medical Program pays benefits for expenses related to wear and tear.

Gender reassignment surgery – includes medical and/or surgical treatments related to alleviating gender dysphoria. Gender dysphoria refers to discomfort or distress that is caused by a discrepancy between a person's gender identity and that person's biology. Covered Expenses determined to be Medically Necessary by BCBSIL may include:

- Psychotherapy,
- Hormone therapy to feminize or masculinize the body, and/or
- Surgery to change primary and/or secondary sex characteristics (e.g., breasts/chest, external and/or internal genitalia, facial features, body contouring).

Contact BCBSIL for more information regarding which services and procedures are considered Medically Necessary, and which are not covered because they are considered cosmetic.

Home Health Care – includes short-term rehabilitative Home Health Care services that are ordered by a Physician and provided by an appropriately licensed Home Health Care Agency. Care must be provided in conjunction with an approved treatment program. Covered Expenses include:

- Part-time or intermittent nursing care provided by or under the supervision of a registered graduate Nurse (R.N.) or Home Health Aide (BCBSIL must approve private-duty nursing care).
- Physical, occupational and speech therapies.
- Consumable medical supplies, drugs and medicines lawfully dispensed only on the written prescription of a Physician, including (but not limited to):
  - Oxygen;
  - Ostomy supplies;
  - Consumable medical supplies as part of authorized inpatient or outpatient facility services;
  - Consumable medical supplies as part of home care when used directly by an authorized, skilled professional; or
  - Authorized consumable medical supplies used in conjunction with authorized Durable Medical Equipment as determined by BCBSIL.
- Laboratory services, but only to the extent that the expenses would have been considered Covered Expenses if the covered individual was Confined in a Hospital as a registered bed patient or confined in a Skilled Nursing and Rehabilitation Facility.
- Dietary supplements and nutritional formula for PKU or other protein absorption deficiencies. The Medical Program also covers nutritional supplements for life-sustaining nutrition that you may receive via a gastrointestinal tube or intravenously in a home setting if you are no longer capable of swallowing.

Home Health Visit – services provided by a registered professional employed by a certified Home Health Care Agency in conjunction with a written treatment program. A two-hour visit provided by a Home Health Aide employed by a certified Home Health Care Agency may be substituted for one visit.

Hospice – services provided in an inpatient facility or outpatient setting if you or a covered dependent is diagnosed as having an incurable disease with a life expectancy of 12 months or less. Covered Expenses determined to be Medically Necessary by BCBSIL include:

- Pre-certified Hospice facility Room and Board for a semiprivate room (private room expenses are covered up to the cost of the facility's highest daily rate for a semiprivate room at the time of the covered individual's confinement);
- Hospice facility services and supplies during the pre-certified confinement;
- Outpatient services provided by a Hospice facility;
- Professional services of a Physician;
- Pain relief treatment, including drugs, medicines and medical supplies;
- Part-time or intermittent nursing care provided in the home by or under a nurse's supervision;
- Part-time or intermittent services provided in the home by a Home Health Aide;

- Consumable medical supplies, drugs and medicines that are lawfully dispensed only on the Physician's written prescription, and laboratory services (only to the extent that such expenses would have been payable if the person had remained or been Confined in a Hospital or Hospice facility); and
- Other Covered Expenses or services that are determined to be Medically Necessary and are authorized by BCBSIL.

Inpatient skilled nursing and rehabilitation – requires precertification, but no prior hospitalization is required. Covered Expenses include:

- Regular daily services and supplies provided by the Skilled Nursing and Rehabilitation Facility (including routine nursing care, prescription drugs, and physical and speech therapy) and covered at the specified percentage of Covered Expenses; and
- Private-duty Nursing services provided by a registered graduate Nurse (R.N.) or an appropriately licensed practical Nurse (other than a close relative of the covered individual). The services must be provided in conjunction with an approved stay in a Skilled Nursing and Rehabilitation facility.

Orthopedic shoes and orthotic appliances – expenses related to foot care treatment for orthotics or corrective shoes.

Outpatient short-term rehabilitation therapies – includes short-term physical, speech and occupational therapy of a restorative nature to treat an injury or illness. Such services must be provided by an appropriately licensed physical, occupational or speech therapist. Speech loss or impairment due to a mental or nervous disorder is not covered. Outpatient short-term rehabilitation therapy is limited to a maximum of 90 visits per calendar year (combined with cognitive and pulmonary rehabilitation therapy). No prior hospitalization is required.

Reconstructive surgery – expenses for surgery required when an individual sustains an illness or an injury that results in bodily damage that requires restoration of a prior functional status, provided it:

- Qualifies as reconstructive surgery following Medically Necessary surgery for the specific illness or injury, or
- Is required to provide or restore a normal bodily function.

Surgical support hose and Jobst® stockings – limited to three pairs per calendar year, when determined Medically Necessary and authorized by BCBSIL.

Telehealth/Telemedicine Services - service delivered by a health professional licensed, certified, or otherwise entitled to practice in Illinois and acting within the scope of the health professional's license, certification, or entitlement to a patient in a different physical location than the health professional using telecommunications or information technology.

Wigs – limited to $500 every 24 months, when Medically Necessary.

MEDICAL PROGRAM TERMS TO KNOW

The definitions in this section apply to services you receive while covered under one of the Medical Program options. BCBSIL may have additional definitions that apply to the services you receive and will always have the discretionary authority to interpret the meaning of these terms and the benefits payable under each option.

Coinsurance – the percentage of Covered Expenses you are responsible for paying. Percentages apply after any applicable Deductible requirement has been met. The percentage you pay (for example, 10%, 20%, 30%, 40%, or 100%) depends on the option you elect, the type of service you receive, and whether you receive in- or out-of-network care. You pay Coinsurance amounts until you reach the annual Out-of-Pocket Maximum. Once you reach the Out-of-Pocket Maximum, the Group Health Program starts to pay benefits for Covered Expenses at 100%.

Key Term

Coinsurance – the percentage of Covered Expenses you are responsible for paying. Percentages apply after any applicable Deductible requirement has been met. The percentage you pay (for example, 20%, 25%, 40% or 100%) depends on the option you elect, the type of service you receive and whether you receive in- or out-of-network care. You pay Coinsurance amounts until you reach the annual Out-of-Pocket Maximum. Once you reach the Out-of-Pocket Maximum, the Plan starts to pay Covered Expenses at 100%.

Copayments or "Copay" – a flat dollar amount that you are responsible for paying for certain covered healthcare services. Your "copays" do not apply toward your Deductible but do apply toward your annual Out-of-Pocket Maximum.

Contract Amount – the predetermined amount to be covered or allowed for a service or procedure as outlined in the Provider contract.

Covered Expense – the expenses that the Group Health Program covers. To be considered covered, an expense must qualify in three ways:

- BCBSIL determines that the expense meets the definition of a Medically Necessary service or supply for the specific illness or injury. Generally, this means the expense must be for treatment that follows acceptable protocols, is required to treat an illness or injury, is prescribed by a qualified professional, is rendered in an appropriate setting, and is recognized as appropriate by BCBSIL in the diagnosis and/or treatment of the specific illness or injury.
- The expense cannot exceed the Maximum Reimbursable Expense for the service or supply as determined by BCBSIL.
- The expense is not included in the list of excluded expenses.

Custodial Services – any service that is not intended primarily to treat a specific injury or sickness (including Mental Illness, alcohol abuse or drug abuse). Custodial Services include:

- Watching or protecting a person;
- Performing or assisting a person in performing any activities of daily living, such as walking, grooming, bathing, dressing, getting in or out of bed, toileting, eating, preparing foods, or taking medications that can be self-administered; and
- Services not required to be performed by trained or skilled medical or paramedical personnel.

Custodial Services do not include Home Health Care to perform routine deep suctioning of the respiratory system when such routine care is the recommended care and treatment for an ongoing medical condition.

Key Term

Deductible – the amount depends on which option you choose and the coverage category you select under the Plan (You Only, You + Spouse, You + Child(ren), or You + Family). The Deductible is the fixed-dollar amount that you pay out of your pocket each plan year before the Plan begins to pay benefits. You can only apply the amounts you incur for Covered Expenses toward your annual Deductible, and any amount that you pay toward your Deductible also is counted toward your annual Out-of-Pocket Maximum (except for the excluded charges listed under the *Out-of-Pocket Maximum* definition below). **Note:** Copayments do not apply to your Deductible.

If you enroll and elect You Only coverage, the individual Deductible applies. If you elect any other coverage category, the family Deductible applies. However, no individual with family coverage will pay more than the embedded individual Out-of-Pocket Maximum as a Deductible, where applicable, in compliance with the Affordable Care Act.

Deductible – the deductible amount depends on which option you choose and the coverage category you select under the Group Health Program (You Only, You + Spouse, You + Child(ren), or You + Family). The Deductible is the fixed-dollar amount that you pay out of your pocket each calendar year before the Group Health Program begins to pay benefits. You can only apply the amounts you incur for Covered Expenses toward your annual Deductible, and any amount that you pay toward your Deductible also is counted toward your annual Out-of-Pocket Maximum (except for the excluded charges listed under the *Out-of-Pocket Maximums* definition under this subsection).

Note: Certain expenses do not apply toward your Deductible, including the following:

- Copayments;
- Any amount you pay above the Maximum Reimbursable Expense when seeking care outside the network;
- Any additional penalty amount you may be required to pay for not obtaining Preauthorization for a Hospital admission or stay (where applicable); and

- Any expense that is not considered a Covered Expense, is above the Contract Amount, or exceeds other Group Health Program limits.

Durable Medical Equipment – equipment that can withstand repeated use, is primarily and customarily used to serve a medical purpose, is not implantable within the body, is generally not useful for a person in the absence of a sickness or injury, and is appropriate for use in the home.

Emergency/Emergencies – medical, psychiatric, surgical, Hospital and related services and testing (including ambulance services) that a prudent layperson (with average knowledge of medical science) believes is needed to treat a sudden or unexpected onset of a bodily injury, a serious medical complication, possible loss of life, or permanent impairment to a bodily function. This is a condition that – if not treated immediately – might cause the loss of a limb or lead to a severe, permanent disability.

Examples of Emergencies include:

- Seizure or loss of consciousness
- Loss of breathing
- Suspected overdose of medication or poisoning
- Broken bones
- Chest pain or a squeezing sensation in the chest
- Severe bleeding
- Burns or cuts
- Shortness of breath
- Sudden paralysis
- Slurred speech
- Severe pain

Emergency Care – regardless of whether you participate in the HSA Value, HSA Advantage, Copay Value, Copay Value Select, or Copay Advantage, in a medical Emergency:

- You or your enrolled eligible dependents can go to any Emergency facility or hospital, even one that is not participating in the network. You do not need authorization for Emergency Care.
- If you or your enrolled eligible dependents go to a Hospital or a facility that does not contract with BCBSIL, you may have to pay the full cost of the Emergency Care, then file a claim for reimbursement.
- Call BCBSIL at the number listed on your ID card if you have questions about submitting your claim.
- If you or your enrolled eligible dependents receive Emergency Care at an out-of-network facility and the Group Health Program does not consider your or their condition to be a true Emergency, you may be responsible for additional costs associated with your claim. Post-Emergency follow-up visits may be covered at the out-of-network benefit level (if applicable given your option) if the treating Emergency room Provider is not a Participating Provider.

Expense – the lesser of:

- The actual billed charges, or
- When the Provider contracts directly or indirectly for a different amount, the Contract Amount.

Experimental or Investigational Services – medical, surgical, diagnostic, psychiatric, substance abuse, or other health care services, technologies, supplies, treatments, procedures, drug therapies, medications or devices that, at the time a determination is made regarding coverage in a particular case, are determined by BCBSIL to be any of the following:

- Not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not identified in AHFS Drug Information or United States Pharmacopeia Dispensing Information as appropriate for the proposed use;
- Subject to review and approval by an institutional review board for the proposed use (devices that are FDA approved under the Humanitarian Use Device exemption are not considered to be Experimental or Investigational); or
- The subject of an ongoing clinical trial that meets the definition of a Phase 1, 2 or 3 Clinical Trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight.

If you have a life-threatening sickness or condition (one that is likely to cause death within one year of the request for treatment), BCBSIL, in its discretion, may consider an otherwise Experimental or Investigational health service to be a Covered Expense for that sickness or condition. Before such consideration, BCBSIL must determine that the procedure or treatment is:

- Provided to be safe and promising;
- Provided in a clinically controlled research setting; and
- Using a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health.

Home Health Aide – a person who provides care of a medical or therapeutic nature. He or she reports to and is under the direct supervision of a Home Health Care agency.

Home Health Care – short-term health care that is ordered by a Physician and provided in the patient's home by a licensed home health care agency. This type of care must be approved by BCBSIL.

Home Health Care Agency – a Hospital, or a nonprofit or public Home Health Care Agency that:

- Primarily provides therapeutic services under the supervision of a Physician or a registered graduate Nurse (R.N.);
- Is run according to rules established by a group of professional persons;
- Maintains clinical records on all patients; and
- Does not primarily provide Custodial Services, or care and treatment of the mentally ill.

A Home Health Care Agency must be licensed and run according to the laws that pertain to agencies in jurisdictions where required.

Hospice – a program of care for a patient whose life expectancy is 12 months or less. The purpose of hospice care is to keep the patient as comfortable as possible and to provide support for the patient's family. Qualified hospice care may be provided at an approved hospice facility, or in the home under the direction of a recognized hospice care program.

Hospital – an institution that:

- Is licensed as a hospital and maintains on its premises all facilities that are necessary for acute medical and surgical treatment;
- Provides such treatment on an inpatient basis, for compensation, under the supervision of Physicians; and
- Provides 24-hour service by registered graduate Nurses (R.N.).

A hospital may be accredited by the Joint Commission on Accreditation of Healthcare Organizations. It can specialize in treatment of Mental Illness, alcohol abuse, drug abuse or other related illnesses. It can provide residential treatment programs and is licensed in accordance with the laws of the appropriate legally authorized authority. An institution that is primarily a place for rest, a place for the aged, or a nursing or convalescent home is not a hospital.

Hospital Confinement or Confined in a Hospital – a period of time during which a person is a registered bed patient in a Hospital and is being treated upon the recommendation of a Physician. In addition, a person is considered confined in a Hospital if he or she is partially confined for the treatment of Mental Illness, alcohol abuse, drug abuse or other related illness. "Partially confined" means that a person is continually treated for at least three hours (but not more than 12 hours in any 24-hour period).

In-Network Benefit Level – the benefit level payable when services are provided by Participating Providers and authorized by BCBSIL.

Inpatient – a patient in an uninterrupted confinement following a formal Hospital, Skilled Nursing and Rehabilitation Facility or Inpatient rehabilitation facility admission. You must be a registered bed patient and treated as such by the facility.

Maximum Reimbursable Expense – the maximum amount that is recognized for a Covered Expense, as determined by BCBSIL. This maximum is based on:

- The amount Participating Providers have agreed to accept as payment in full for a particular Covered Expense,
- For Non-Participating Providers, the Maximum Reimbursable Expense is the lesser of the:
  - Provider's billed charges, or
  - Medicare reimbursement rate as determined by the Center for Medicare & Medicaid Services (CMS).

Note: The non-contracting Maximum Reimbursable Expense for Coordinated Home Care will be 50% of the Non-Participating Provider's standard billed charge for such Covered Expenses.

Any change to the Medicare reimbursement amount will be implemented by BCBSIL within 145 days after the effective date that such change is implemented by CMS.

If you receive your care from a Participating Provider, the reimbursable rates are already negotiated at a rate that does not exceed the Maximum Reimbursable Expenses. If, however, you or your enrolled eligible dependents receive care from a Non-Participating Provider (or if you or your enrolled eligible dependents participate in the BCBSIL Indemnity option), you are responsible for paying any amount over the Maximum Reimbursable Expenses.

Any amount in excess of the Maximum Reimbursable Expense does not count toward your annual Deductible or your annual Out-of-Pocket Maximum.

Note: BCBSIL for your Group Health Program option may use other terms to describe the Maximum Reimbursable Expense. For example, BCBSIL may use the terms "eligible expense," "usual and customary charge (U&C)" or "reasonable and customary charge (R&C)" to describe this concept.

Medically Necessary or Medical Necessity – the determination made by BCBSIL of whether an expense will qualify as a Covered Expense. The determination is based on whether the:

- Service is for the treatment, diagnosis or symptoms of an injury, disease or condition (including pregnancy);
- Service is consistent with the diagnosis and is appropriate given the symptoms;
- Type, level and length of care; the treatment or medical supply; and the setting are appropriate and needed to provide safe and adequate care; and
- Care is not generally regarded as Experimental, Investigational or research in nature.

Note: Log in to BCBSIL's website: **bcbsil.com/rrd** or call **1-800-537-9765** to review BCBSIL's medical policies.

Mental Illness – any disorder, other than a disorder induced by alcohol or drug abuse, that impairs an individual's behavior, emotional reaction or thought process, regardless of medical origin. In determining benefits, charges made for the treatment of any physiological symptoms related to a mental illness are not considered made for the treatment of a mental illness.

Necessary Services and Supplies – any charges, except for Room and Board, made by a Hospital for medical services, and supplies actually used while an individual is Confined in a Hospital. Does **not** include any charges for special nursing fees, dental fees or medical fees.

Non-Participating Provider – a Provider who does not have a contractual relationship with BCBSIL for the option in which you are enrolled. In certain limited instances, you may be able to have a Non-Participating Provider treated as if he or she is a Participating Provider. For example, where a Participating Provider is not available within your geographic region or if the waiting time for an appointment is excessive. If you would like to use a Non-Participating Provider because a Participating Provider is not available, contact BCBSIL to obtain a review of the circumstances and Preauthorization of the services if your situation meets BCBSIL's medical management guidelines.

Nurse – a registered graduate nurse (R.N.), a licensed practical nurse (L.P.N.) or a licensed vocational nurse (L.V.N.).

Nurse Practitioner – a licensed medical practitioner operating within the scope of his or her license in the state in which he or she is practicing medicine and performing a service for which benefits are provided under the Group Health Program.

Out-of-Network Benefit Level – the benefit level that is payable when services or supplies are provided by Non-Participating Providers or when unauthorized by BCBSIL.

Key Term

Out-of-Pocket Maximum – the most you have to pay in Coinsurance for Covered Expenses for you and your enrolled eligible dependents in any calendar year. Once you reach the Out-of-Pocket Maximum, the Group Health Program pays 100% of your additional Covered Expenses for the remainder of that calendar year. The Out-of-Pocket Maximum rules vary based on your option.

If you enroll and choose individual coverage, you will only need to meet the individual out of pocket limit before the Group Health Program begins to pay benefits at the 100% level. If you elect any other coverage category, the total coverage category Out-of-Pocket Maximum applies collectively to all enrolled persons in the same family. However, the Group Health Program will begin to pay benefits at the 100% level for any member of the family whose expenses reach the single out-of-pocket maximum required by the Affordable Care Act even if the family out-of-pocket maximum has not been met (this is called the "Embedded Out-of-Pocket Maximum").

Certain expenses, however, do not apply toward the Out-of-Pocket Maximum. These include:

- Any amount you pay above the Maximum Reimbursable Expense when seeking care outside the network;
- Any additional penalty amount you may be required to pay for not obtaining Preauthorization for a Hospital admission or stay (where applicable); and
- Any expense that is not considered a Covered Expense, is above the Contract Amount, or exceeds other Group Health Program limits.

Out-of-Pocket Maximum – the annual Out-of-Pocket Maximum is the most you have to pay in Coinsurance (including Copayments) for Covered Expenses for you and your enrolled eligible dependents in any calendar year. Once you reach the Out-of-Pocket Maximum, the Group Health Program pays 100% of your additional Covered Expenses for the remainder of that calendar year. The Out-of-Pocket Maximum rules vary based on your option.

If you enroll and choose individual coverage, you will only need to meet the individual Out-of-Pocket Maximum before the Group Health Program begins to pay benefits at the 100% level. If you elect any other coverage category, the total coverage category Out-of-Pocket Maximum applies collectively to all enrolled persons in the same family. However, the Group Health Program will begin to pay benefits at the 100% level for any member of the family whose expenses reach the single out-of-pocket maximum required by the Affordable Care Act even if the family out-of-pocket maximum has not been met (this is called the "Embedded Out-of-Pocket Maximum"). Once the family out-of-pocket maximum is met, the Group Health Program

will pay benefits at the 100% level for all covered members of the family, even for family members who have not met the individual out-of-pocket maximum.

Outpatient Surgical Facility – an institution that has a staff of Physicians, Nurses and licensed anesthesiologists that maintains at least two operating rooms and one recovery room, a diagnostic laboratory, and x-ray facilities. It must have equipment for Emergency Care, maintain a blood supply and maintain medical records. The facility must have an agreement with Hospitals for immediate acceptance of patients who need Hospital Confinement on an Inpatient basis. It also must be licensed in accordance with the laws of the appropriate legally mandated agency.

Participating Provider – a Provider that has a contractual relationship with BCBSIL for the option in which you are enrolled.

Action Steps – Check Provider Directories

A complete list of Participating Providers (including mental health and substance abuse providers) is available online at all times and will be provided to you as a printed separate document upon request and free of charge. For the most current list of Participating Providers, or to confirm your provide is in the network, call BCBSIL at **1-800-537-9765**.

- Visit **bcbsil.com/find-a-doctor-or-hospital**. If you sign into your account, you get a personalized list specific to your plan. Otherwise, you need to enter your health plan or network, which is shown on the front of your BCBSIL member ID card.
- If you have questions about which network you have, call the Customer Service number on the back of your card.

Physician (or Provider) – a medical practitioner who practices within the scope of his/her license and is licensed to prescribe and administer drugs or to perform surgery. A provider is any other licensed medical practitioner whose services or supplies are required to be covered by law in a certain area if he/she is operating within the scope of his/her license and performing a service or supply for which benefits are provided under the Group Health Program.

Preauthorization – a requirement that you must obtain authorization from BCBSIL before you receive certain types of otherwise Covered Expenses in order to be eligible for maximum benefits.

Preexisting Condition – a condition for which an individual receives medical care, treatment, advice or medication before the Group Health Program coverage effective date. Preexisting condition limitations do not apply under the Group Health Program.

Primary Care Providers (PCPs) – use of a PCP is not required to be eligible for benefits under the Group Health Program. However, this provider is still a good resource for your general health and for recommending specialists if you need them. PCPs may be general or family practitioners, OB/GYNs, internists or pediatricians. You may choose any PCP you like, but if your PCP is not in the network, you will pay more for your PCP visits. For a list of network PCPs, see the BCBSIL website at **https://www.bcbsil.com/find-a-doctor-or-hospital** or call BCBSIL member services.

Private-duty Nursing – skilled nursing services rendered by a registered graduate Nurse (R.N.), a licensed practical Nurse (L.P.N.) or a licensed vocational Nurse on a per-shift, part-time or intermittent basis. Such services or supplies are part of a treatment plan supervised by a licensed Physician. Private-duty nursing services or supplies may be provided as part of a confinement or as part of a home health plan. If you receive private-duty nursing services while confined, such services or supplies are considered skilled nursing services and the applicable skilled nursing services maximums would apply.

Psychologist – a person who is licensed or certified as a clinical psychologist. Where no license or certification exists, this term means a person who is considered qualified as a clinical psychologist by a recognized psychological association. The term also can include any other licensed counseling practitioner whose services are required to be covered by law in a certain area if he or she is operating within the scope of his or her license and is performing a service for which benefits are provided under this Group Health Program when provided by a psychologist. The term also can include any psychotherapist while he or she is providing care authorized by BCBSIL if he or she is state-licensed or nationally certified by his or her professional discipline, and is performing a service or providing a supply for which benefits are paid under this Group Health Program when provided by a psychologist.

Room and Board – all expenses made by a Hospital or other approved patient care facility on its own behalf for room and meals, and for all general services or supplies and activities that are needed for the care of a registered bed patient.

Skilled Nursing and Rehabilitation Facility – an approved facility where an individual recovers from an illness or injury. The individual must be under the continuous care of a Physician during the skilled nursing or rehabilitation facility confinement, and the Physician must certify that 24-hour-a-day nursing care is essential.

Specialty Care – a Physician with a specialty who is not a PCP. You do not have to get a referral from a PCP if you need to see a specialist. If you visit a specialist without a PCP referral, the Group Health Program still pays benefits at the in-network level (provided an in-network specialist provides the care).

Urgent Care – if Urgent Care symptoms are present, you should contact your carrier to locate your closest Urgent Care facility. Urgent care symptoms can include severe sore throat, sprains and strains, ear or eye infections, or fever. A prudent layperson, with average knowledge of medical science, can determine that Urgent Care is necessary to treat such a symptom that requires prompt medical attention. This does not include care that could have been foreseen before leaving the immediate area where the patient would ordinarily receive and/or was scheduled to receive services. If you have questions about Urgent Care coverage, call BCBSIL at the phone number listed on your ID card.

Medical, surgical, Hospital and related health care services and testing that are not usually considered Emergencies or that would not typically require Urgent Care should be handled through a scheduled office visit with your doctor. These situations include:

- Routine physicals
- Immunizations
- Colds or flu
- Follow-up checks on injuries or broken bones
- Prescription drug needs

WHAT'S NOT COVERED

The Medical Program options do not cover all services and supplies. BCBSIL makes a determination as to whether an expense is a Covered Expense in accordance with its internal protocols and medical management guidelines. The following expenses are **not** Covered Expenses of the Medical Program options (unless otherwise indicated):

- Expenses incurred before your coverage effective date.
- Services, treatments and supplies that are not reasonably necessary for medical care or to treat an illness or injury, as determined by BCBSIL (except as specifically outlined under preventive care).
- Medicine, supplies or services that are not ordered by a properly licensed Physician (or another properly licensed practitioner of the healing arts) who is acting within the scope of his or her license.
- Certain drugs that have limited clinical value and which have clinically appropriate, lower-cost alternatives (e.g., brand name drugs that are combinations of existing generic or over-the-counter drugs, new formulations of existing drugs).
- Testing or checkup procedures that are not necessary to diagnose or treat an illness or injury (except as specifically outlined under preventive care).
- Experimental and Investigational services or unproven services, unless the Medical Program has agreed to cover them as stated within. This exclusion applies even if the Experimental and Investigational or unproven service is the only available treatment option for the condition.
- Educational or Experimental treatments, procedures, devices, drugs or medicines for which one or more of the following are true:
  - The service or supply is not approved for marketing by the FDA at the time the device, drug or medicine is furnished.
  - The treatment method is not approved by the American Medical Association or the appropriate medical specialty society, or published in authoritative medical and scientific material.
  - The treatment, procedure, device or drug is the subject of ongoing trials to determine tolerated dose, toxicity, safety or efficacy.
- Routine physicals or mental health or substance abuse exams and administrative documentation that are not required for health reasons but are required for (but not limited to):
  - Employment, insurance, school or athletic exams;
  - Government licenses; or
  - Court-ordered, forensic, foreign travel or custodial evaluations (except if the physical exam would have been performed as part of a routine exam and is within the scope of regular preventive care services covered under the Medical Program).
- Vaccinations and inoculations for any purpose outside covered Preventive Care, including non-employment-related foreign travel (except as specifically outlined under preventive care).

- Expenses for vision services, including hardware and eye exams unless to treat a sickness or injury. The Medical Program pays benefits for the purchase of contacts or eyeglasses only when necessary to treat a sickness or injury (this includes the first pair after cataract surgery).
- Expenses associated with the replacement of an external prosthetic appliance due to loss, theft or destruction; or for any biomechanical external prosthetic appliance.
- Tests and treatments that are directly related to the actual or attempted impregnation or fertilization that involves the covered individual as a surrogate, donor or recipient, including (but not limited to):
  - Artificial insemination;
  - In vitro fertilization;
  - Infertility surgical treatment;
  - Gamete intrafallopian transfer (GIFT);
  - Zygote intrafallopian transfer (ZIFT); and
  - Depo-Provera, when administered in the office of a Provider who does not participate in the network (except as part of adjunctive therapy and palliative treatment of inoperable, recurrent and metastatic endometrial or renal carcinoma).
- Services or supplies that are related to penile prostheses, except appliances such as semi-rigid internal or erectoid vacuum external prosthetics used to correct a neurogenic bladder of organic etiology.
- Services or supplies that are related to the reversal of voluntary sterilization.
- Cosmetic surgery or procedures, unless:
  - While covered under the Medical Program, you are injured and your injury results in bodily damage that requires reconstructive surgery;
  - It qualifies as reconstructive surgery following Medically Necessary surgery for the specific illness or injury;
  - It is required to provide or restore a normal bodily function;
  - It is considered Medically Necessary in light of an underlying medical diagnosis in accordance with BCBSIL's medical management guidelines; or
  - It is cosmetic surgery or therapy to repair or correct severe facial disfigurements or severe physical deformities that are congenital or result from developmental abnormalities (other than abnormalities of the jaw or TMJ disorder); tumors; trauma; disease; complications of Medically Necessary, non-cosmetic surgery or reconstructive surgery to correct a congenital birth defect; or developmental abnormalities performed before the age of 19.
- Services or supplies that are related to breast augmentation (except as outlined immediately above).
- Nursing care and speech, occupational or physical therapy provided by you, your spouse or your spouse's child, sibling or parent.
- Expenses associated with maintenance care, or any service that you may receive to maintain a level of function at which no demonstrable and/or measurable improvement of condition will occur.

- Exercise and maintenance therapies designed to improve general physical condition, including (but not limited to) Phase III cardiac and pulmonary rehabilitation.
- Outpatient rehabilitative therapy provided by a licensed physical, occupational or speech therapist that is neither short-term nor restorative in nature, or that is in excess of the stated benefit level.
- Routine outpatient treatment of a structural imbalance, distortion or subluxation of the vertebrae (except for outpatient rehabilitative therapy, up to the maximum benefit level).
- Routine chiropractic adjustments and manipulation, except for the treatment of a specific musculoskeletal disorder up to the maximum benefit level.
- Custodial Care that helps with functions of daily living and personal needs.
- Educational services or supplies, when the primary purpose is one of the following:
  - Training in the activities of daily living (except training that is directly related to an illness or injury that results in a loss of a previously demonstrated ability),
  - Scholastic instruction,
  - Vocational training,
  - Treatment of a learning disability, or
  - Prenatal instruction and exercise classes.

  Educational services or supplies also include any service or supply that is designed to promote development beyond any level of function previously demonstrated.
- Expenses made by a Provider, to the extent they result from scholastic, educational or vocational training (as determined by BCBSIL).
- Consumable medical supplies, except as noted in the **What's Covered** section.
- Non-medical services and supplies, such as:
  - Air conditioners;
  - Air filters or non-allergenic blankets; and
  - Modifications made to a home, property or automobile (such as ramps, elevators, spas, air conditioners and car hand controls).
- Artificial aids, including (but not limited to) corrective orthotic devices and orthopedic shoes (except if Medically Necessary), dentures, garter belts, corsets and wigs (except if Medically Necessary).
- Hygienic or self-help items, environmental control items, and institutional or athletic items.
- Expenses made by a Physician for or in connection with a surgery that exceeds the following maximum (only applies if you receive care from a Non-Participating Provider): When two or more surgical procedures are performed at one time, the maximum amount covered is the amount that otherwise would be covered for the most expensive procedure, and one-half of the amount that would otherwise be covered for all surgical procedures.
- Expenses made by an assistant or co-surgeon in excess of 20% of the primary surgeon's allowable charge. **Note:** Under the BCBSIL Group Health Program, the charges apply

regardless of whether you receive care from a Participating Provider or a Non-Participating Provider.

- Any expense that is made for or in connection with tired, weak or strained feet for which treatment consists of routine foot care, including (but not limited to) the removal of calluses and corns, or the trimming of nails (unless Medically Necessary for orthotic appliances or corrective orthopedic shoes).
- Nutritional supplements provided in the home setting for a condition such as diabetes mellitus, anorexia, bulimia and amino acid deficiency.
- Transportation expenses via an air ambulance, unless Medically Necessary for the specific illness or injury (BCBSIL determines the Medical Necessity for an air ambulance).
- Non-covered services and penalties associated with the failure to obtain Preauthorization for a Hospital admission or surgery.
- Expenses related to an injury or disease that is covered by Workers' Compensation or similar law.
- Expenses for or in connection with an injury that arises out of or in the course of any employment for wage or profit.
- Services and supplies you receive:
  - By or from the U.S. government, or any other government unless payment of the expense is required by law; or
  - By any law or government plan under which you, your spouse or your child(ren) is or could be covered.
- Expenses related to a sickness or injury due to a declared or undeclared act of war.
- Expenses in connection with injuries that result from acts of armed aggression by you or your covered dependents who commit such acts while covered by the Plan.
- Expenses for you or your covered dependents that would in any way be paid or be entitled to payment by or through a public program (other than Medicaid).
- Expenses for which payment is unlawful where you reside when the expense is incurred.
- Expenses that you are not legally required to pay.
- Expenses that would not have been paid if you had no coverage.
- Expenses for late or missed appointments.
- Expenses related to the transfer of medical records.
- Expenses incurred as a result of an accident for which, in the opinion of BCBSIL, third-party liability exists. In such case, the Plan shall have the right to subrogation.
- Court-ordered treatments, unless deemed Medically Necessary for the specific illness or injury.
- Expenses under the mandatory part of any auto insurance policy written to comply with:
  - A "no-fault" insurance law, or
  - An uninsured motorist insurance law.
- Elective medical care that is received outside the United States that falls outside the terms of the Blue Cross Blue Shield Global Core® Program.
- Organ transplant travel services associated with cornea transplants, costs incurred due to travel within a specific number of miles of the home (miles dependent upon your

option), laundry bills, telephone bills, alcohol and tobacco products, and transportation charges that exceed coach class rates.

- The Medical Program does not pay benefits if you or your covered dependent is a donor.
- Dental services, other than those listed under **What's Covered**, or for oral surgery to remove impacted teeth, or to operate on gums or mouth as long as the operation is not performed for routine extractions or repairing of teeth.
- Dental services, other than those listed under **What's Covered,** rendered in a case of TMJ dysfunction syndrome that affects the jaw but not the teeth.
- Expenses in excess of Maximum Reimbursable Expenses.
- Expenses that a third party is obligated to cover, such as under another plan or insurance policy, or a tort recovery or Workers' Compensation recovery by you.
- Foreign language and sign language interpreters.
- Enteral nutrition, including infant formula available over the counter, unless it is the only source of nutrition.
- Expenses for care that is not provided at an appropriate treatment facility or in an appropriate setting. Appropriate treatment facilities generally do not include half-way houses, supervised living, group homes, wilderness programs, boarding houses, or other facilities that provide primarily a supporting environment and that address long-term social needs, even if counseling is provided in such facilities.

PREAUTHORIZATION

To help ensure that you receive appropriate care, you (or your Provider) must generally obtain Preauthorization for any Hospital admission and for other services indicated in this booklet. If your Provider obtains Preauthorization of your care on your behalf, it is your responsibility to ensure the Group Health Program's Preauthorization requirements have in fact been met. You can obtain Preauthorization for services by calling BCBSIL at the number listed on your ID card.

Note: Preauthorization does not guarantee benefits will be payable. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of the Group Health Program.

Hospital Admissions Subject to Preauthorization

You are required to obtain Preauthorization for three types of admissions:

- Inpatient Hospital (medical, surgical, mental health and substance abuse) admission;
- Emergency admission; and
- Maternity admission.

Length of Stay/Service Review

A length of stay/service review does not guarantee benefits. Actual benefit availability is subject to eligibility and the other terms, conditions, limitations and exclusions of your coverage option.

An extension to your length of stay/service is based solely on whether BCBSIL determines that continued Inpatient care or other health care services are Medically Necessary. If it is determined that an extension is not Medically Necessary, your length of stay/service will not be extended. Your case is then referred to BCBSIL's physician for review.

Preauthorization Procedures

You must call BCBSIL to preauthorize a scheduled Inpatient Hospital admission at least **24 hours before** admission. For Emergency and Maternity admissions, you or someone who calls on your behalf must notify the Claim Administrator no later than **48 hours or as soon as reasonably possible after** the admission has occurred.

When you call, provide all of the following:

- Name of the attending and/or admitting Physician,
- Name of the Hospital where the admission is scheduled and/or the location where the service is scheduled,
- The scheduled admission and/or service date, and
- A preliminary diagnosis or reason for the admission and/or service.

The toll-free phone number is listed on your ID card. Your regular Physician or authorized specialist may work directly with BCBSIL to obtain Preauthorization for your Hospital admission. However, it is your responsibility to make sure your Hospital stay is approved.

When you contact BCBSIL, BCBSIL reviews your request, and you and your Physician are notified as soon as possible regarding the approved length of stay. If your request for hospitalization is not approved, BCBSIL discusses your case with your Provider to reach an agreement regarding the appropriate treatment to follow.

Emergency Notification

In the case of an Emergency, go directly to the nearest Emergency facility or call 911. If admitted, you, a family member or your Provider must call BCBSIL within 48 hours after the admission. If you do not, the level at which the Group Health Program pays benefits may be impacted as described below in the "Failure to Notify" section.

Failure to Notify

The final decision regarding your course of treatment is solely your responsibility. BCBSIL does not interfere with your relationship with any Provider. However, BCBSIL has established Preauthorization procedures to help you determine the course of treatment that will maximize your benefits. Your benefits are **reduced by $500 if you fail to obtain Preauthorization for a Hospital admission.** This means that you are responsible for paying $500 more than you would have paid if you had obtained Preauthorization for the admission.

$500 Preauthorization Penalty

If you have to pay the Preauthorization penalty, it does not apply to your annual Deductible or your Out-of-Pocket Maximum. **The $500 Preauthorization penalty is not a Covered Expense.** In addition, any other Covered Expense for a hospitalization, surgery or an unauthorized day **may be denied.** This means your share of out-of-pocket costs could be significantly higher.

Other Services Subject to Preauthorization

BCBSIL has established a Utilization Review Program to assist you in determining the course of treatment that will maximize your benefits under the Medical Program. In addition to the Inpatient Hospital services listed above, the Utilization Review Program requires a review of the following Covered Expenses before maximum benefits for such services are available:

- Skilled Nursing and Rehabilitation Facility services
- Home Health Care services
- Private-duty Nursing services
- Certain outpatient procedures (described in the following section).

Whenever these services are recommended by your Physician, in order to receive maximum benefits under the Medical Program, you must call BCBSIL at the number on your ID card at least two business days prior to receiving services.

Outpatient Service Preauthorization Review

Outpatient service Preauthorization review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of the Medical Program.

Whenever the following outpatient procedure(s)/services(s), are recommended by your Physician, in order to receive maximum benefits under the Medical Program, you must call BCBSIL at the number on your ID card. This call must be made at least two business days prior to receiving these services:

- Coordinated Home Care Program services
- Home hemodialysis
- Home Hospice
- Home Infusion Therapy
- All Home Health Care services
- Outpatient Infusion Drugs
- Private-duty Nursing
- Transplant evaluations

Cardiac (Heart related):

- Diagnostic Heart Catheterization
- **Cardiac Advanced Imaging Services:** MRI, Magnetic Resonance Angiogram (MRA), PET, PET-CT, CT, Computed Tomography Angiography (CTA), Nuclear Medicine
- Lipid Apheresis

Ears, Nose and Throat (ENT):

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

Gastroenterology (Stomach):

- Gastric Electrical Stimulation (GES)

Neurological:

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

Orthopedic (Musculoskeletal):

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

Pain Management:

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

Radiology:

- **Advanced Imaging Services:** MRI, Magnetic Resonance Angiogram (MRA), PET, PET-CT, CT, Computed Tomography Angiography (CTA), Nuclear Medicine (including Cardiology)

Sleep Medicine:

- Diagnostic Attended Sleep Studies

Surgical Procedures:

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

Wound Care:

- Hyperbaric Oxygen (HBO2) Therapy

Specialty Pharmacy:

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

Non-Emergency Fixed-Wing Ambulance Transportation:

- Non-Emergency Fixed-Wing Ambulance Transportation

You should also call BCBSIL before receiving the following outpatient services from a Non-Participating Provider:

- Dialysis
- Elective Surgery

SPECIAL SERVICES

If you enroll in one of the national Group Health Program options, the following special services are available to you through BCBSIL.

Health Advocacy Solutions

As a Medical Program participant, you are eligible to receive additional support concerning your medical care. Health Advocacy Solutions is a free concierge service from BCBSIL. Health Advocacy Solutions offers teams of Health Advocates (including registered Nurses, social workers, and health and behavioral advocates), who are available 24/7 to help you and your covered family members with all your health care matters. Below are some examples of how Health Advocates can help:

- Understand and use your health benefits.
- Find high-quality, cost-effective providers.
- Schedule your appointments.
- Find answers to your health questions.
- Sort out a new diagnosis and what to do next.
- Coordinate complex care needs.
- Deal with claims issues.
- Earn Member Rewards (see below) for making smart health care choices.

You can find out more about Health Advocacy Solutions and reach a Health Advocate by calling **1-800-537-9765**.[1]

Member Rewards Program

The Member Rewards Program allows you to save money and earn cash rewards when you compare costs and select a cost-effective option for your care. If your doctor suggests a medical procedure or service, you can take advantage of the Member Rewards Program by using the online BCBSIL Provider Finder (available through the Blue Access for Members website) or by calling a Health Advocate so you can compare your choices and select a reward-eligible location. After you have your procedure or service at a reward-eligible location and the claim is paid, you will receive a check in the mail.

To learn more about the Member Rewards Program or find a reward-eligible location for services, call **1-800-537-9765**.[2]

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1 Health advocates do not replace the care of a doctor and you should talk to your doctor about any medical questions or concerns.
2 Incentives are available for select procedures only. Amounts you receive through Member Rewards may be taxable. Rewards may be delivered by check or an alternative form of payment. If you have coverage under Medicaid or Medicare you are not eligible to receive incentive rewards under the Member Rewards program.

Member Rewards Program Incentive

Participants who use the Member Rewards Program may receive an incentive payment.

Here are some common procedures and the reward range:

Service	Potential cash reward
Colonoscopy	$50 - $250
CT scan	$50 – $150
MRI	$50 - $150
Mammogram	$25 - $50

Hinge Health

Hinge Health is an innovative digital program for chronic back, knee or hip pain. You will receive a free tablet and wearable sensors so you can complete a personalized exercise therapy regimen that is shown to reduce pain from chronic conditions. The app on the tablet also provides access to unlimited one-on-one coaching to support you. This optional program is available at no cost to you and your dependents enrolled in a Medical Program option described in this booklet.

To learn more about Hinge Health, call **1-800-537-9765**.

MyEvive

MyEvive is a personal online health hub that makes it easy to find, organize and use your RRD health benefits, including pharmacy, dental and vision. MyEvive can send personal care reminders, custom health alerts and more to your email or mobile device.

For more information about MyEvive, call the number on the back of your BCBSIL member ID card.

Talk to a Nurse

When a health problem pops up late in the day or in the middle of night, it can be hard to know how serious it is. Should you go to the emergency room? Urgent care? Or, can it wait until you can see your regular doctor? Call **1-800-537-9765** – 24/7 Nurseline – for help. Nurses can answer health questions, day or night. Call any time with questions about:

- Dizziness or severe headaches
- Cuts or burns
- Back pain
- High fever

- Sore throat
- A baby's nonstop crying
- And other health issues

Plus, when you call, you can access an audio library of health topics – from allergies to surgeries.

Vision Care Discounts

You have access to vision care discounts through Blue365®.

Blue Access for Members℠

Stay connected and get the most from your plan. You can use our secure member website to:

- Use BCBSIL's Provider Finder® tool to search for an in-network doctor, hospital or other facility
- Request or print a member ID card
- Check the status or history of a claim
- View or print explanation of benefits statements
- Use the Cost Estimator tool to find the price of hundreds of tests, treatments and procedures
- Sign up for text or email alerts
- And much more

As soon as you get your member ID card, follow these easy steps to sign up.

1. Go to **bcbsil.com/rrd**
2. Click Log In
3. Use the information on your member ID card to sign up

Get the App

Access all of BCBSIL's mobile websites and services in one spot. Text **BCBSIL** to **33633** to get started.

Take Advantage of Discounts

Blue365 is just one more advantage of being a BCBSIL member. With this program, you may save money on health care products and services from top retailers that are not covered by insurance. Once you register for Blue365 at **blue365deals.com/bcbsil**, you will receive weekly "Featured Deals" by email. These deals offer special savings for a short period of time.

Your Health Matters

After you sign up for Blue Access for Members, click the My Health tab for more information about the programs described below.

Live Well with Well onTarget®

The Well onTarget portal and mobile app can help you manage your health and reach your wellness goals – all in one place. Well onTarget brings you the following features:

Check Your Health Status

Find out how your health measures up by taking a Health Assessment. Answer a few questions about your health and lifestyle. Then, get a personal report that suggests programs that can help you improve your health. Participation is completely voluntary and your results and kept confidential.

Improve Your Health and Wellbeing

You have anytime, anywhere access to videos, podcasts, self-directed courses and other tools to help you with things like:

- Asthma
- Back pain
- Diabetes
- Eating well
- Exercise
- Sleep issues

Work with a Coach

Get one-on-one support by phone or online messaging – whatever works for you. Your health coach can help you set and reach goals like losing weight, improving your blood pressure and quitting smoking.

Track Your Progress

Logging how much you move and what you eat can help you stay on course. Link your fitness devices and nutrition apps in Well onTarget or use the built-in tracking tools in the portal. Either way, you'll easily see all your tracked stats in one place.

Reward Yourself

Earn Blue Points℠ when you:

- Take a Health Assessment
- Link a fitness device
- Complete a self-directed course
- Work with a health coach

Redeem your points for books, music, sporting goods – anything that motivates you to keep making healthy choices.

Focus on Fitness

The Fitness Program gives you flexible options to help you live a healthy lifestyle and gives you access to a nationwide network of fitness locations. Choose one location close to home and one near work or visit locations while traveling. Call BCBSIL to find out about the flexible gym network!

- **Studio Class Network:** Boutique-style classes and specialty gyms with pay-as-you-go option and 30 percent off every 10th class.
- **Family Friendly:** Expands gym network access to your covered dependents at a bundled price discount.
- **Convenient Payment:** Monthly fees are paid via automatic credit card or bank account withdrawals.

It's easy to sign up:

- Go to **bcbsil.com/rrd** and log in to Blue Access for Members.
- Under **Quick Links**, choose **Fitness Program**. On this page, you can enroll, search for nearby fitness locations and learn more about the program.
- Click **Enroll Now**. Then search and select the fitness location that is best for you. Remember, you can visit any participating gym after you sign up.
- Verify your personal information and method of payment. Print or download your Fitness Program membership ID card. You may also request to receive the ID card in the mail.
- Visit a fitness location today! Prefer to sign up by phone or have questions about the Fitness Program? Just call **800-537-9765**.

Take Care of Your Mental Health

Your mental health is just as important as your physical health. Your plan includes behavioral health benefits, so you can get care for:

- Alcohol or drug use
- Stress
- Depression
- Eating disorders
- Anxiety
- Autism
- And other mental health or substance use conditions

Log in at **bcbsil.com/rrd** to find a mental health Provider near you.

Connect with a Cancer Specialist

Cancer can be a scary word. BCBSIL cancer Nurses want to make it a little less scary. They can help you understand your care options and your health benefits. And they'll be there to support you throughout your journey – from finding a Provider through treatment and beyond.

Get Ready for Baby

If you plan to add to your family, you have help to prepare. Apps from Ovia Health™ can guide you step-by-step through fertility, pregnancy and parenting. If you have a high-risk pregnancy, you'll also get phone support from a BCBSIL maternity specialist.

Ovia Fertility

- Understand and track your cycle
- Read daily articles and tips just for you
- Find out when you are most fertile

Ovia Pregnancy Tracker

- Watch your baby grow week by week
- Read daily articles and tips just for you
- Look up food and medication safety
- Watch helpful videos about pregnancy
- Use tools to plan your return to work

Ovia Parenting

- Learn about your child's health and development
- Read thousands of expert parenting articles and tips
- Receive tools and support for balancing life as a working parent
- Share family photos and videos with loved ones

All programs include in-app support from a registered Nurse. Download one or all the apps in the Apple App Store or the Google Play store to get started.

Specialty Care

Hospitals and medical facilities that meet specific quality standards have earned the Blue Distinction® designation[14], giving you a credible, easily identifiable means of selecting facilities that meet your individual health care needs. Each Blue Distinction® Center has demonstrated its commitment to quality care, resulting in better overall outcomes for patients.

Blue Distinction Centers are available for these specialty health care services:

- Bariatric surgery
- Cardiac care
- Transplants
- Complex and rare cancers
- Knee and hip replacement surgery
- Spine surgery

To search for Blue Distinction Centers, click **Provider Network** tab at **bcbsil.com/rrd**.

Virtual Visits

Getting sick is never convenient and finding time to get to the doctor can be hard. You can get help with non-Emergency medical issues and behavioral health needs through MDLIVE®. Video chat or talk to a doctor on your schedule. Register using one of these methods:

- Go to Blue Access for Members or visit **MDLIVE.com/bcbsil**
- Download the MDLIVE app at the Apple App Store or Google Play
- Call MDLIVE at **1-888-676-4204**
- Text BCBSIL to 635483

Go to **bcbsil.com/rrd** to find more information and links to the programs and services described in this document. Or call a health advocate at **1-800-537-9765** for help 24/7.

Livongo for Diabetes and Livongo for Hypertension

The Group Health Program offers Livongo for Diabetes and Livongo for Hypertension under the Medical Program options described in this booklet to you and your covered dependents diagnosed with diabetes and/or hypertension as applicable, at no cost to you. Both benefits include coaching services for enrolled participants. Livongo for Diabetes also provides participants with a cellular connected blood glucose meter for condition monitoring, a lancing device and unlimited test strips. Livongo for Hypertension also provides participants with a blood pressure monitor and cuff. Contact **Livongo** at **1-800-945-4355** for more information.

BCBSIL Inter-Plan Arrangements – Out-of-Area

BCBSIL has a variety of relationships with Blue Cross and/or Blue Shield Licensees. Generally, these relationships are called “Inter-Plan Arrangements.” Inter-Plan Arrangements work based on rules and procedures issued by the Blue Cross Blue Shield Association. Whenever you (or your enrolled eligible dependents) access health care services outside the geographic area BCBSIL serves, claims for those services may be processed through one of these Inter-Plan Arrangements. The Inter-Plan Arrangements are described on the next page.

When care is received outside of BCBSIL's service area (i.e., outside of the "Home Blue" service area), you will receive it from one of two kinds of Providers:

- Participating Providers **contract with** the local Blue Cross and/or Blue Shield Plan in that geographic area (Host Blue), or
- Non-Participating Providers **don't contract with** the Host Blue.

How the Medical Program pays both kinds of Providers is explained below. You should carefully review the provisions in **Non-Participating Providers Outside BCBSIL's Service Area** with respect to the amount payable under the Medical Program when you receive services from a Non-Participating Provider in non-Emergency situations.

All claim types are eligible to be processed through Inter-Plan Arrangements.

BlueCard® Program

Under the BlueCard® Program, when covered services are received within the geographic area served by a Host Blue, the Medical Program will be responsible for doing what BCBSIL agreed to do in its contract with that Host Blue. However, each Host Blue is responsible for contracting with and generally handling all interactions with its Participating Providers.

When covered services are received outside BCBSIL's service area and the claim is processed through the BlueCard® Program, the amount you pay for covered services generally is calculated based on the lower of the:

- Billed charges for covered services, or
- Negotiated price that the applicable Host Blue makes available to BCBSIL.

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

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

Negotiated (Non-BlueCard® Program) Arrangements

With respect to one or more Host Blues, instead of using the BlueCard® Program, BCBSIL may process claims for covered services through a "Negotiated Arrangement" for "National Accounts." A Negotiated Arrangement is an agreement negotiated between your Home Blue and one or more Host Blues for any National Account that is not delivered through the BlueCard® Program. A National Account is a plan sponsored by an employer (like RRD) that is headquartered in a Home Blue's service area but that has employees/participants in other geographic areas served by a Host Blue.

The amount you pay for covered services under a Negotiated Arrangement generally is calculated based on the lower of the:

- Billed charges for covered services, or
- Negotiated price that the applicable Host Blue makes available to BCBSIL (refer to the description of negotiated price under **BlueCard® Program**)

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

Special Cases: Value-Based Programs

A Value-Based Program (VBP) is an outcomes-based payment arrangement and/or a coordinated care model facilitated with one or more local Providers that is evaluated against cost and quality metrics/factors and is reflected in Provider payment. See below for the definitions of these and other capitalized terms used in this section.

VBP Definitions

Accountable Care Organization (ACO) – a group of health care Providers who agree to deliver coordinated care and meet performance benchmarks for quality and affordability to manage the total cost of care for their member populations.

Care Coordination – organized, information-driven patient care activities intended to facilitate the appropriate responses to a member's health care needs across the continuum of care.

Care Coordinator – an individual within a Provider organization who facilitates Care Coordination for patients.

Care Coordination Fee – a fixed amount paid by a Blue Cross and/or Blue Shield Licensee to Providers periodically for Care Coordination under a VBP.

Global Payment/Total Cost of Care – a payment methodology that is defined at the patient level and accounts for either all patient care or for a specific group of services delivered to the patient such as outpatient, Physician, ancillary, hospital services and prescription drugs.

Patient-Centered Medical Home (PCMH) – a model of care in which each patient has an ongoing relationship with a primary care Physician who coordinates a team to take collective responsibility for patient care and, when appropriate, arranges for care with other qualified Physicians.

Provider Incentive – an additional amount of compensation paid to a health care Provider by a Blue Cross and/or Blue Shield Plan, based on the Provider's compliance with agreed-upon procedural and/or outcome measures for a particular group of covered persons.

Shared Savings – a payment mechanism in which the Provider and payer share cost savings achieved against a target cost budget based upon agreed upon terms and may include downside risk.

You may access covered services from providers that participate in a VBP, such as an ACO, Global Payment/Total Cost of Care Arrangement, a PCMH, and/or a Shared Savings arrangement.

BlueCard® Program

If you receive covered services under a VBP inside a Host Blue's service area, you will not be responsible for paying any of the Provider Incentives, risk-sharing, and/or Care Coordinator Fees that are a part of such an arrangement, except when a Host Blue passes these fees to BCBSIL through average pricing or fee schedule adjustments. Additional information is available upon request.

Negotiated (Non-BlueCard Program) Arrangements

If BCBSIL has entered into a Negotiated Arrangement with a Host Blue to provide VBPs to the BCBSIL Medical Program, BCBSIL will follow the same procedures for VBP administration and Care Coordinator Fees as described above with respect to VBPs under the BlueCard Program.

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

Federal or state laws or regulations may require a surcharge, tax or other fee that applies to self-funded accounts. If applicable, BCBSIL may include any such surcharge, tax or other fee as part of the claim charge passed on to the Medical Program.

Non-Participating Providers Outside BCBSIL's Service Area

If you receive covered services from a Non-Participating Provider in a non-Emergency situation, the amount the Medical Program pays for the covered services will be the lower of the:

- Non-Participating Provider's billed charges, or
- Medicare reimbursement rate as determined by the Centers for Medicare & Medicaid Services (CMS). (See the definition of **Maximum Reimbursable Expense**).

If you receive covered services from a Non-Participating Provider, you will be responsible for the difference between what the Non-Participating Provider charges and what the Medical Program pays. Because that amount is in excess of the Maximum Reimbursable Expense, it does not count toward your annual Deductible or your annual Out-of-Pocket Maximum.

If you receive covered services from a Non-Participating Provider in an Emergency situation, the amount the Medical Program pays for the covered services will be determined in accordance with the Patient Protection and Affordable Care Act.

Coverage When You Travel

For added peace of mind when you're far from home, you have access to doctors and hospitals in more than 190 countries around the world through the Blue Cross Blue Shield Global® Core7 program. Customer Service Advocates can help you find a doctor or treatment facility and can even help set up an appointment.

Blue Cross Blue Shield Global Core® Program

If you are outside the United States, Commonwealth of Puerto Rico and U.S. Virgin Islands (the BlueCard service area), you may be able to use the Blue Cross Blue Shield Global Core® Program when accessing covered services. While the Blue Cross Blue Shield Global Core® Program assists you with accessing a network of Inpatient, outpatient and professional Providers, the network is not served by a Host Blue. So, when you receive care from Providers outside the BlueCard service area, you typically pay the Providers and submit claims yourself for reimbursement.

Call for Care Outside BluCard Service Area

If you need medical assistance services (including locating a doctor or hospital) outside the BlueCard service area, you should call the service center at **1-800-810-BLUE (1-800-810-2583)** or call collect at **1-804-673-1177,** 24 hours a day, seven days a week. An assistance coordinator, working with a medical professional, can arrange a Physician appointment or hospitalization, if necessary.

Inpatient Services

In most cases, if you contact the service center for assistance, Hospitals will not require you to pay for covered Inpatient services at the time of service, except for your cost-share amounts, Deductibles or Coinsurance. In such cases, the Hospital will submit your claims to the service center to begin claims processing. However, if you paid in full at the time of service, you must submit a claim to receive reimbursement for covered services. You must contact BCBSIL to obtain Preauthorization for non-Emergency Inpatient services.

Outpatient Services

Physicians, Urgent Care centers and other outpatient Providers located outside the BlueCard service area will typically require you to pay in full at the time of service. You must submit a claim to obtain reimbursement for covered services.

Submit a Blue Cross Blue Shield Global Core® Program Claim

When you pay for covered services outside the BlueCard service area, you must submit a claim to obtain reimbursement. For institutional and professional claims, you should complete a Blue Cross Blue Shield Global Core® Program claim form and send the claim form with the Provider's itemized bills to the address is on the form to initiate claims processing. Follow the instructions on the claim form to help the timely processing of your claim. Claim forms are available from BCBSIL, the service center or at **bcbsglobalcore.com**. If you need assistance with your claim submission, call the service center at **1-800-810-BLUE (1-800-810-2583)** or call collect at **1-804-673-1177,** 24 hours a day, seven days a week.

PRESCRIPTION DRUG PROGRAM

The Prescription Drug Program described throughout this Group Health Program Booklet is available to you and your enrolled eligible dependents, provided you enroll for coverage under the Group Health Program. Your Prescription Drug Program claims administrator is Caremark.

Prescription Drug Terms to Know

Certain terms have special meaning under the Prescription Drug Program. The definitions provided in this section apply to services you receive while covered under the Prescription Drug Program. These are in addition to the key terms already defined in prior sections (which also apply). Caremark may have additional definitions that may apply to the services you receive and will always have the discretionary authority to interpret the meaning of these terms and the benefits payable under the Prescription Drug Program.

Maintenance Medications – a list, as Caremark designates, of prescription drug products that are commonly prescribed for long-term use. This list is subject to periodic review and modification. Contact Caremark to obtain a copy of the list of maintenance medications.

National Drug Code Number (NDC#) – the national classification system used to identify drugs. This code is an 11-digit number. This number is required on the claim form you complete to receive reimbursement for costs you incur through the use of a retail non-Participating Pharmacy.

Participating Pharmacy – a pharmacy that is part of Caremark's network and contracts to provide services for the Prescription Drug Program. Contact Caremark for a free listing of participating pharmacies, or view the current listing on Caremark's website at **caremark.com** or download the Caremark app for iPhone or Android to access the pharmacy search tool.

Key Term

Cost-sharing – the amount a participant is required to pay for a prescription in accordance with the Prescription Drug Program (this may include a Deductible, a percentage of the prescription's price, or a fixed amount or other expense). The Prescription Drug Program then pays the balance (if any).

The Prescription Drug Program and/or claims administrator may receive rebates or other discounts in connection with your prescriptions. The amount you are required to pay as cost-sharing is based on the price of the prescription before the application of any rebate or other discount.

Prescription Order – a Physician's lawful authorization for a prescription drug or related supply. The Physician must be duly licensed to make such authorization within the course of his or her professional practice or each authorized refill thereof.

Primary/Preferred Drug List – a clinically based drug list that contains FDA-approved brand-name and generic medications for a broad range of medical conditions or diseases. While Physicians are encouraged to prescribe medications that are on the Primary/Preferred Drug List, it is still the Physician's responsibility to determine the most appropriate medication for each patient. Using a primary/preferred drug, where available and medically appropriate, can reduce your out-of-pocket expenses. For a complete listing of the current Primary/Preferred Drug List and to confirm whether a drug listed on the Primary/Preferred Drug List is covered by the Prescription Drug Program, visit **caremark.com** or call **1-866-273-8402**.

How Prescription Drug Coverage Works

The Prescription Drug Program pays a percentage of Covered Expenses or flat dollar amount once you meet your coverage option's applicable Deductible, if any.

The Prescription Drug Program pays benefits using three different cost-sharing levels, or "tiers." Each tier then refers to a drug's classification on the Primary/Preferred Drug List. As a result, the amount you pay depends on all of the following:

- The option you select under the Medical Program
- Which tier of drug classification you elect on the Primary/Preferred Drug List, including:
  - Generic
  - Brand formulary (on Caremark's approved list, except as noted in the **What's Not Covered** section)
  - Brand non-formulary (not on Caremark's approved list and as noted in the **What's Not Covered** section)
- Whether you obtain your prescription drug service from a Participating or non-Participating retail pharmacy
- Whether you receive your prescription through the mail service

The Maintenance Choice Program requires participants to purchase a 90-day supply of certain maintenance medications at a retail pharmacy. See **Maintenance Choice Program** for more information.

Dispense as Written (DAW) Penalty

If a generic drug is available, but your doctor notes "Dispense as Written/No Substitutions" on the prescription for the brand name drug, you will generally be required to pay the Coinsurance plus the difference between the generic and the brand price. In some cases, this extra cost-sharing may be waived where the brand drug is Medically Necessary (for example, if taking a brand oral contraceptive is Medically Necessary, the additional cost-sharing would be waived as required by the Affordable Care Act). Contact Caremark at the phone number listed on your prescription drug ID card for more information regarding such Medical Necessity determinations.

Filling Prescriptions at a Retail Pharmacy

Caremark selects a network of retail pharmacies that offer reduced prices to covered individuals. You are not required to file a claim if you receive benefits from a Participating Pharmacy, you show your prescription drug ID card, or Caremark verifies your eligibility at the point at which you fill your prescription. Your prescription drug ID card is generally separate from your medical ID card.

You can obtain a list of Participating Pharmacies by contacting Caremark at the phone number listed on your prescription drug ID card or by visiting Caremark's website at **caremark.com** or through the pharmacy search tool on Caremark app for iPhone or Android.

You also can purchase prescription drugs at a non-Participating Pharmacy. However, you are required to pay the prescription's full cost at the time of your purchase and you must submit a claim form to for reimbursement.

Presenting a prescription for fill at a pharmacy counter is not a submission of a formal claim under the Group Benefits Plan. To initiate these formal claims and appeals procedures, you must submit a Prescription Drug Claim Form as described in the *Administrative Booklet*.

Filling Prescriptions Through the Mail Service Pharmacy

If you need to take a prescription drug for an extended period of time, you should purchase such prescriptions through the mail (maximum 90-day supply). Your medications are delivered to your home. Purchasing prescription drugs through the mail service pharmacy enables you to minimize your out-of-pocket costs for long-term maintenance prescriptions.

To fill your prescriptions through the mail service pharmacy:

- Complete a confidential Mail Service Order Form when you submit your first prescription by mail. It is important to complete the form for all individuals for whom you are requesting a prescription. If you change or add medications, or you have a medical condition that you did not previously report, you must update your profile.
- Ask your Provider to write a prescription for a 90-day supply, plus the appropriate refills for up to a maximum of one year. (After the one-year period, a new prescription is required.) Submit the original prescriptions with the covered individual's name and ID number clearly marked on the back. Also include the completed Mail Service Order Form (you may want to keep a copy for your records).
- Submit your payment (either by check or credit card number). If you pay by credit card, you can order refills by phone or online (provided your original prescription is valid). After you use all of the refills noted on the original prescription, you need to submit a new prescription as outlined above.

You can obtain a copy of the Mail Service Order Form by contacting Caremark at the phone number listed on your prescription drug ID card or by visiting Caremark's website at **caremark.com.**

Maintenance Choice Program

You can save time and money by getting a 90-day supply of your maintenance medication filled at your local CVS pharmacy, including those inside Target stores, OR mailed directly to your home. You must use this program after the first fill for long-term medications or your prescription won't be covered by the plan.

If you use the Mail Service to fill your 90-day supply, you can choose to spread your payments over three months. The Maintenance Choice Program does not apply to one-time or short-term medications (those taken for 90 days or less).

To learn more about the CVS Maintenance Choice and Mail Service Programs, visit **caremark.com** or call **1-800-268-5187.**

Important! Make Sure Your Maintenance Medication Is Covered

If you continue to order 30-day supplies of your maintenance medications after the first fill without using the CVS pharmacy Maintenance Choice Program or Caremark Mail Service, your coverage will be denied (you pay the full cost of the refill).

Prior Authorization

Certain drugs require Caremark's authorization before they are covered under the Prescription Drug Program. Drugs that require prior authorizations are noted in the Check Drug Cost tool on the Caremark website with a "PA" notation. The list of drugs that require step therapy is subject to change from time to time and may not be all-inclusive. You can log onto **caremark.com** to check your specific medicine coverage or call Customer Care toll-free at **1-888-528-7457.**

If your prescription requires prior authorization, begin the prior authorization process by taking your prescription to a participating retail pharmacy or submitting it to Caremark's mail service program. Caremark then works with the pharmacist and your Physician to obtain the necessary information to make an appropriate coverage decision. This process can take up to two business days to complete. Once Caremark makes a decision, it processes your mail service prescription or contacts the retail pharmacy to communicate whether or not the coverage was approved. If your medication is not approved, you can appeal by calling Caremark at the phone number listed on your prescription drug ID card.

Step Therapy

The step therapy program is another form of prior authorization. This program encourages you and your doctors to start treatment with an appropriate generic medicine with a lower Copay before "stepping up" to higher-priced brand drugs for certain drug classes. Examples of affected drug classes include: acne, allergy, asthma, enlarged prostate, glaucoma, headache, high blood pressure, high cholesterol, insomnia, osteoporosis and urinary incontinence.

Using the standard protocol, certain drugs are not covered unless participants have tried one or more "prerequisite therapy" medication(s) first. The look-back period for determining if a generic has previously been attempted is generally 12-18 months, depending on the drug class.

If Medically Necessary/appropriate, your Physician can work with Caremark to request a medical exception for approval to use a brand drug as initial therapy without trying a prerequisite therapy drug. If no other generic option is available, your doctor may provide clinical documentation to Caremark to obtain prior approval so you may receive coverage for a brand drug. Without prior approval, the brand-name medicine may not be covered and you may have to pay the full cost.

The list of drugs that require step therapy is subject to change from time to time and may not be all-inclusive. Drugs that require step therapy or other prior authorizations are noted in the Check Drug Cost tool on the Caremark website with a "PA" notation. You can log onto **caremark.com** to check your specific medicine coverage or call Customer Care toll-free at **1-888-528-7457.**

Diabetes Supplies and Insulin

Diabetes supplies and insulin are covered at 100%.

What's a Covered Expense

The Prescription Drug Program covers outpatient prescription drugs (including injectables) that are approved for use by the FDA, Medically Necessary, prescribed by a licensed Provider and dispensed by a licensed pharmacy. Caremark makes a determination as to whether an expense is a Covered Expense.

For a complete listing of the current Primary/Preferred Drug List and to confirm whether a drug listed on the Primary/Preferred Drug List is covered by the Prescription Drug Program, visit **caremark.com** or call **1-866-273-8402**. See the subsection titled **What's Not Covered** for specific information about medications that may be listed on the formulary provided by Caremark but that are not covered under the Prescription Drug Program.

Quantity Limits

Certain drugs will have a quantity limit in place. This means only a certain number of pills or days' worth of medication will be available over a 30-day period. This is done to ensure appropriate, safe usage. Please contact Caremark to confirm whether your drug has any quantity limits in place.

What's Not Covered

Caremark makes a final determination as to whether an expense is a Covered Expense. The following expenses are not Covered Expenses of the Prescription Drug Program:

- Drugs prescribed for cosmetic purposes only (for example, topical minoxidil, Rogaine®, etc.)
- Brand name proton pump inhibitor (PPI) drugs used to treat gastrointestinal disorders
- Drugs available without a prescription, except insulin
- Prescription drugs, when there is an over-the-counter equivalent available without a prescription
- Over-the-counter smoking cessation products, including nicotine gum and patches (Prescription smoking cessation products are covered up to a dollar limitation. Once the dollar limitation is met, these services are no longer covered.)
- Infertility medications
- Weight-loss medication, unless prior authorization is issued by Caremark
- Nail fungal treatment, unless prior authorization is issued by Caremark
- Medical supplies and equipment (syringes and needles used to administer insulin, as well as alcohol swabs, lancets and devices are not excluded from coverage)
- Experimental, investigational, or unproven drugs or therapies as defined by the FDA
- Replacement prescription drugs that result from loss or theft
- Medications with no approved FDA indications
- Compound prescription medications that do not contain at least one covered legend drug
- Expenses to the extent that you or your enrolled eligible dependents are in any way paid or entitled to payment for those expenses by or through a public program (other than Medicaid)
- Expenses to the extent that payment is unlawful where you reside
- Expenses you incur related to an injury or disease that is covered by Workers' Compensation or similar law
- Expenses that you or your enrolled eligible dependents are not legally required to pay
- Expenses you or your enrolled eligible dependents incur before the coverage effective date
- Expenses in connection with a Mental Illness or injury that is due to a declared or undeclared act of war, including armed aggression
- Any "service" expense

Prescription Drug Savings Program — Rx Savings Solutions

You may be able to save money on your medications with Rx Savings Solutions, a confidential online tool that finds lower-cost options for your prescribed medications. Rx Savings Solutions will automatically notify you via text or email (based on your preference) whenever it finds savings available to you. This optional program is available at no cost to you and your dependents enrolled in a Medical Program option described in this booklet.

Action Steps – Rx Savings Solutions

Save money on your medications with Rx Savings Solutions!

Find More Information	Go to **myRRDbenefits.com** for more information.
Search for Medication Tool	Use the Search for Medications tool to find savings suggestions.

COORDINATING BENEFITS WITH OTHER PROGRAMS

The Group Health Program has a coordination of benefits (COB) provision that coordinates benefit payments from all of your and your enrolled eligible dependents' coverages. For example, if your spouse also has coverage through his or her employment, the COB provision coordinates payments from the Group Health Program and your spouse's plan. This provision is intended to prevent duplicate payments for the same covered expenses.

Coordination of benefits takes into account benefits available for the same expenses under another employer plan, a governmental program such as Medicare or TRICARE, or benefits required by law, such as no-fault automobile insurance benefits. The Group Health Program always pays primary to Medicaid.

Coordination of benefits will be coordinated by the claims administrator.

How Coordination of Benefits Works

When you have a claim for an expense that is covered by two or more health plans, one pays benefits first. The plan that pays benefits first is known as the primary plan. The other plan, called the secondary plan, then determines how much of the covered expense, if any, is to be paid from that plan. In general, if the benefit paid by the secondary plan would be higher than the benefit paid by the primary plan, then the secondary plan may pay the difference between what the primary plan paid and what the secondary plan benefit would normally pay.

When the Group Health Program is primary, it pays the amount allowable under the Group Health Program. When the Group Health Program is secondary, it pays the amount necessary so that the total amount you receive from the Group Health Program and the primary plan combined is no greater than the amount you would have received under the Group Health Program alone.

For example, assume that your enrolled eligible dependent has other health plan coverage that is primary and pays first. After his or her primary plan processes the claim, the Group Health Program then determines how much it will pay. The benefit is calculated in the usual way (applying any deductible, coinsurance percentage, penalties, and other limits), then the amount paid by the primary plan is subtracted from this amount, and you are paid the difference.

If the primary plan pays more than what the Group Health Program would pay, then you do not receive a benefit from the Group Health Program. If the primary plan pays less than what the Group Health Program would pay, you receive the difference between the two benefit amounts from the Group Health Program.

Group Health Plans

A group health plan without a COB provision is always considered primary. If all plans have COB provisions, the following rules apply to determine which plan pays first:

- Member/Dependent. A plan that covers a patient as the primary member (e.g., an active employee or a primary qualified beneficiary under COBRA) is primary over a program that covers the patient as an enrolled eligible spouse or dependent.
- Active/Inactive Member. A plan that covers a patient as an active employee (or an enrolled eligible spouse or dependent of an active employee) is primary over a plan that covers the patient as a retiree (or an enrolled eligible spouse or dependent of a retiree) or COBRA qualified beneficiary.
- Dependent Children of Parents not Separated or Divorced. When both parents have medical coverage for their child(ren), the program of the parent whose birthday comes earlier in the calendar year is primary.
  - 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.
  - If no other provision determines which coverage is primary, then the older parent's plan will pay first.
- Dependent Children of Parents not Separated or Divorced. If the parents are divorced or legally separated, special rules apply:
  - The program of the natural parent with primary custody of an enrolled child is primary.
  - If the natural parent with primary custody remarries, the program of the stepparent with custody pays second, the program of the parent without custody pays third, and the program of the stepparent without custody pays last.
  - However, if a court decree places financial responsibility for the enrolled child's care on one parent, that parent's program always pays first, regardless of who has custody of the child. Then, the program of the parent with custody pays second, the program of the stepparent with custody pays third, and the program of the stepparent without custody pays last.
- Longer/Shorter Length of Coverage. If none of the above rules determine the order of benefits, the plan covering a person longer pays first. The plan covering that person for a shorter time pays second.

The claims administrator may ask you, on an annual basis, to provide or confirm information about other programs under which you and your enrolled eligible dependents are covered.

HMOs

If you and your enrolled eligible dependents have primary coverage under an HMO, the Group Health Program does not coordinate with that HMO's coverage. This means that no payment is made from the Group Health Program as the secondary program. Any COB rules regarding your HMO benefits are governed by the HMO.

Medicare

Medicare is a federal program available to individuals who are age 65 or older or who have received Social Security disability benefits for two continuous years. Your medical benefits under the Group Health Program are coordinated with Medicare as explained earlier in this section. Federal law determines how benefits are coordinated when a person has coverage under the Group Health Program and also is entitled to Medicare. For example, sometimes the Group Health Program coverage is primarily responsible for medical claims and Medicare will pay certain expenses not paid by the Group Health Program (that is, Medicare is secondary). Other times, Medicare will be primarily responsible for paying medical claims and the Group Health Program will be secondary.

Active employees, or their enrolled eligible spouse/domestic partner, or child(ren) who are eligible for Medicare due to permanent kidney failure have coverage under the Group Health Program as their primary coverage for the first 30 months of renal dialysis or following a kidney transplant (even after you cease to be a covered active employee, but only if you elect COBRA coverage). After 30 months, Medicare coverage becomes primary and the Group Health Program is secondary. Once the Group Health Program becomes secondary for a person that became entitled to Medicare, it will not become secondary for other enrolled eligible dependents. For example, if John and his wife both have coverage under the Group Health Program and John later becomes eligible for Medicare because he is diagnosed with end stage renal disease, the Group Health Program will become secondary for John after 30 months, but not his wife if she also does not have end stage renal disease.

Active employees, or their enrolled eligible spouse, or child(ren) who are eligible for Medicare due to age or disability (other than permanent kidney failure) have coverage under the Group Health Program as their primary coverage for so long as they remain an enrolled active employee. This is NOT the case for Domestic Partners. See the callout box titled **Special Rules: Domestic Partners and Medicare** below for more information.

Creditable Coverage and Medicare Premium Penalties

Medicare Part D

RRD determined that the prescription drug coverage options offered under the Group Health Program are, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and are therefore considered Creditable Coverage for Medicare Part D. Therefore, if you enroll in Group Health Program coverage, you do NOT also need to enroll in Medicare Part D, and you will not pay a higher premium (a penalty) if you later decide to join a Medicare Part D drug plan.

Medicare Part B

The Creditable Coverage rules for Medicare Part B are different. While you are an active employee, your Group Health Program coverage may or may not be creditable for Medicare Part B, depending on your situation. For purposes of Medicare Part B, creditable coverage means:

- Employer group health plan coverage that is provided to you in connection with your own current employment status, and
- Employer group health plan coverage that is provided to you in connection with your spouse's current employment status.

Coverage is considered to be in connection with an employee's current employment status if the eligible employee is actively working. Coverage is generally NOT in connection with an employee's current employment status if the eligible employee is retired, if the eligible employee terminates employment and elects COBRA continuation coverage, if the eligible employee is absent from work due to disability in excess of six months, or for employees who have been receiving Medicare due to End Stage Renal Disease in excess of 30 months. In those cases, if you do not enroll for Medicare Part B at your earliest opportunity, then you will need to wait until the next Medicare Part B annual enrollment period (January through March each year, with coverage effective July 1) before you will have another opportunity to enroll for coverage, and when you do enroll you will have to pay a premium penalty.

Contact Medicare at 1-800-MEDICARE (1-800-633-4227) for more information about Medicare Part B special enrollment periods and premium penalties. TTY users can call 1-877-486-2048.

Note: Where Medicare would be primary, the Group Health Program presumes that you will enroll in Medicare Parts A and B once you are eligible to do so. This means the Group Health Program will **not** pay expenses for which Medicare is primarily responsible under federal law, regardless of whether you have actually enrolled in Medicare. If you do not enroll in Medicare and you have end stage renal disease, you will only have secondary coverage under the Group Health Program after 30 months and will be left without any primary coverage.

Special Rules: Domestic Partners and Medicare

For Medicare Part B purposes, coverage generally is not creditable if it is provided by a domestic partner's employer. Domestic partners generally will be required to enroll in Medicare Part B at their earliest opportunity (otherwise they will not have special enrollment rights if other coverage is lost and they will have to pay a premium penalty). There is an exception in some cases if the domestic partner is eligible to enroll in Medicare due to disability (rather than age) and if the employer sponsoring the health plan employs 100 or more employees.

If a domestic partner is eligible for Medicare Part B but does not enroll, then the Group Health Program will reduce/offset Plan benefits and pay secondary as if the domestic partner had enrolled in Medicare and Medicare had paid primary (even if it did not). This would leave the domestic partner with very little benefits under the Group Health Program. Therefore domestic partners should enroll in Medicare Part B at their first opportunity in order to maintain adequate coverage.

COBRA coverage and other post-termination coverage (e.g., retiree medical plan coverage) is not creditable for Medicare Part B. Under the terms of the RRD Retiree Plan, you must enroll in Medicare Part B at your first opportunity and change from the Pre-65 to the Post-65 Retiree Plan options at that time.

Contact Medicare at 1-800-MEDICARE (1-800-633-4227) for more information about Medicare Part B special enrollment periods and premium penalties. TTY users can call 1-877-486-2048.

TRICARE

TRICARE is the federal health care program for U.S. uniformed service members, retirees, and their families around the world. Federal law determines how benefits are coordinated when a person has coverage under the Group Health Program and also is entitled to TRICARE.

Medicaid

Medicaid provides health coverage to eligible low-income adults, children, pregnant women, elderly adults and people with disabilities. Medicaid is administered by states, according to federal requirements. The program is funded jointly by states and the federal government. The Group Health Program always pays primary to Medicaid.

Automobile Insurance Benefits

The Group Health Program's liability for expenses arising out of an automobile accident will always be secondary to any automobile insurance.

Other Government Programs

For other government health care programs (e.g., CHIP, Indian Health Service, etc.) the Group Health Program will defer to the government health care program's coordination of benefits rules to determine which plan pays first.

Group Health Program Information

See the *Administration Booklet* for who's eligible, how to enroll, claims and Appeals procedures, Plan administrative information, and information about your ERISA rights.