Wolters Kluwer

Wolters Kluwer

United States, Inc.

Medical Plan

Summary Plan Description (SPD)

Effective January 1, 2019

Contents

An Introduction to Your Medical Coverage

Overview

Health care—especially hospitalization—can be costly. That's why your medical coverage provided under the Wolters Kluwer United States Inc. Health Plan (the “Plan”) is an important part of your Wolters Kluwer United States Inc. (WKUS) benefits.

The Plan offers a variety of coverage options—such as the Blue Cross Blue Shield Enhanced HSA Plan, the Core HSA Plan, and the PPO Plan (collectively referred to as the “Blue Cross Blue Shield National coverage options”), and, in a few regional areas, a Health Maintenance Organization (HMO). This material details the rules on eligibility, enrollment, termination of coverage, and other matters pertinent to these coverage options. It also details what the Plan covers and how the Plan pays benefits if you select one of the Blue Cross Blue Shield National coverage options.

This material doesn't describe HMO coverage in detail. Instead, it refers you to other sources from which you can obtain detailed information that constitutes the Summary Plan Description (SPD) for your insured HMO coverage. The Your Benefits Resources™ website also links you to detailed HMO information.

This is your Summary Plan Description (SPD) for the Plan's Blue Cross Blue Shield National coverage options. It describes the basic features of these coverages under the Plan (as of January 1, 2019), which is a group health benefit plan of Wolters Kluwer United States Inc. (WKUS)—also referred to as the *Company*. These are the self-insured coverages, which mean benefits are paid from the general assets of WKUS. Blue Cross Blue Shield provides certain administrative services for these options under the Plan's medical coverages, such as *claims* processing. CVS Caremark (for self-insured Blue Cross Blue Shield coverage options) also administers prescription drug coverage for participants in these options. In addition, certain terms are italicized throughout this content. These terms are further defined within the “Glossary” main section.

This SPD is written to comply with disclosure requirements under the Employee Retirement Income Security Act (ERISA) of 1974 (as amended). These regulations require that the rights, benefits, and limitations of such a plan be explained in language that can be understood by the average plan participant. This material, however, doesn't describe the complete Plan. Keep in mind that the SPD is based on official legal documents that govern the operation of the Plan. Some features of the Plan, particularly those that apply infrequently, aren't included in this summary. More detailed information is provided in the official Plan documents. While every effort has been made to make this SPD as accurate as possible, if there are any inconsistencies between this SPD and the provisions of the Plan documents, the provisions of the Plan documents will govern. Plan benefits are paid only if provided for in the official Plan documents. The Plan cannot be changed without an official Plan amendment. A verbal representation by a *Company* employee or individual cannot amend the Plan.

Wolters Kluwer United States Inc. intends to continue the Plan indefinitely. Because it's impossible to predict what will happen in the future, however, the *Company* (acting through its Board of Directors or the Board's authorized delegate) reserves the right to amend or discontinue the Plan or any benefit provided under the Plan or to change the cost of coverage under the Plan at any time and for any reason in its sole discretion.

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Finally, the Plan is one component of the Wolters Kluwer United States Inc. Group Health & Welfare Benefits Plan (the “WKUS Group Plan”). As such, the Plan is subject to the terms and conditions and official plan documents for the WKUS Group Plan.

Questions?

If you have difficulty understanding any part of this content, contact a Your Benefits Resources Customer Service Representative at **1-866-520-3280**. Customer Service Representatives are available from 8 a.m. to 8 p.m. Eastern time, Monday through Friday (except holidays).

State Eligibility Laws and the Employee Retirement Income Security Act of 1974 (ERISA)

States sometimes pass laws that require a benefit plan to provide benefits and/or coverage to an individual who otherwise would not be eligible. For example, a state might require an employer to provide coverage to an ex-spouse or a child who exceeds the Plan's age requirements or who would otherwise not be eligible for coverage under the *Company's* Plan.

The federal law known as ERISA supersedes state law. As a result, the *Company* only covers individuals outlined here.

However, if you elect a fully insured coverage option, such as an HMO coverage option, the HMO may be required to comply with particular state laws. It's the HMO's responsibility to determine whether it must comply.

Patient Protections

The Plan generally allows for but doesn't require the designation of a primary care *provider*. You have the right to designate any primary care *provider* who participates in the Plan's network and who is available to accept you or your family members. For information on how to select a primary care *provider*, and for a list of the participating primary care *providers*, contact Your Benefits Resources or, if you are a re-enrolling participant, contact your health plan directly.

For children, you may designate a pediatrician as your child's primary care *provider*.

You don't need prior authorization from the Plan or from any other person (including a primary care *provider*) in order to obtain access to obstetrical or gynecological care from a health care professional in the Plan's network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures. These may include obtaining prior authorization for certain services, following a pre-approved treatment plan, or following procedures in place for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact Your Benefits Resources or contact your health plan directly.

A Snapshot of Your Enhanced HSA Coverage

HSA, Deductibles, Coinsurance, Out-of-Pocket Maximums, and Maximum Benefits

Here is a snapshot of the health reimbursement account contribution, annual *deductibles*, *coinsurance*, annual out-of-pocket maximums, and maximum benefits that apply under the Enhanced HSA coverage option. Many of these terms are defined under the "How Your Coverage Works" main section.

	Enhanced Health Savings Account (HSA)	
Feature	**Network**	**Out-of-Network (Maximum Allowance Limits Apply)***
Annual Health Savings Account (HSA) Company Contribution	**Company Contributes (contributions may be made quarterly but no later than semi-annually)**	
▪ Employee Only	$800	
▪ Employee + Spouse or Employee + Child(ren)	$1,400	
▪ Family	$1,600	
Annual Health Savings Account (HSA) Employee Maximum Contribution	**You May Contribute Up to...**	
▪ Employee Only	$2,700	
▪ Employee + Spouse or Employee + Child(ren)	$5,600	
▪ Family	$5,400	

* The Plan pays benefits for *eligible expenses*. For *out-of-network care*, *eligible expenses* are based on the *maximum allowance*. You're responsible for any charge that exceeds the *maximum allowance*.

	Enhanced Health Savings Account (HSA)	
Feature	**Network**	**Out-of-Network (Maximum Allowance Limits Apply)***
	You Pay	**You Pay**
Annual Deductible (HSA is included in deductible amount)		
▪ Employee Only	$1,500	$3,000
▪ Employee + Spouse or Employee + Child(ren)[±]	$2,700	$5,400
▪ Family[±]	$3,000	$6,000
Annual Out-of-Pocket Maximum (includes deductible; includes network/out-of-network providers)		
▪ Employee Only	$4,500	$9,000
▪ Employee + Spouse or Employee + Child(ren)[±±]	$6,850	$13,700
▪ Family[±±]	$6,850	$13,700
	Plan Pays	**Plan Pays**
Coinsurance	Generally, 90% of Negotiated Fees for Eligible Expenses (after deductible)	Generally, 70% of Maximum Allowance for Eligible Expenses (after deductible)
▪ Blue Distinction Centers required for transplants and bariatric; optional for knee/hip replacement, spine, cardiac care, and rare cancers, but provides a higher level of benefit	100% after deductible Benefits also may be payable for travel and lodging expenses.	No coverage
Lifetime Maximum Benefit	No Limit	

[±] The full family deductible must be met before the Enhanced HSA Plan option pays benefits for eligible expenses. The deductible maximum can be satisfied by one individual's or a combination of covered family member's eligible expenses.

[±±] The full family out-of-pocket maximum must be met before the Enhanced HSA Plan option pays 100% of eligible expenses for the remainder of the calendar year. The out-of-pocket maximum can be satisfied by one individual's or a combination of covered family member's eligible expenses.

	Enhanced Health Savings Account (HSA)	
Feature	**Network**	**Out-of-Network (Maximum Allowance Limits Apply)***
Maximum Benefits	**Plan Pays Benefits For ...**	
▪ Coordinated Home Health Care or Skilled Nursing	Up to 120 Visits Per Calendar Year (applies to all combined covered network and out-of-network services)	
▪ Private Duty Nursing Care	Up to 70 Days Per Calendar Year	
▪ Outpatient Short-Term Rehabilitation (physical, occupational, and speech therapy)	Up to 60 Combined Visits Per Calendar Year (applies to all combined covered network and out-of-network services; limitations may apply)	
▪ Spinal Disorders (spinal manipulations performed by an M.D., D.O., chiropractor, or therapist)	Up to 60 Visits Per Calendar Year (applies to all combined covered network and out-of-network services, limitations may apply, subject to review at 20 visits)	
▪ Family Planning	Limited to the diagnosis and treatment of the underlying cause of infertility only	
▪ Transplant Services (coordination by patient with transplant coordinator; Blue Distinction Center is required)	Requires preauthorization and use of **claims administrator-approved Human Organ Transplant Programs** required to receive benefits. Benefits also are payable for travel and lodging expenses.	
▪ Well-Child Care (includes routine immunizations, travel immunizations, and flu shots)	No limit on routine care	70% of Maximum Allowance for Eligible Expenses (after deductible)
▪ Adult Routine Physical Exams (includes routine immunizations and flu shots)	No limit on routine care	70% of Maximum Allowance for Eligible Expenses (after deductible)
▪ Well-Woman Care	No limit on routine care	70% of Maximum Allowance for Eligible Expenses (after deductible)
▪ Routine Mammograms	No limit on routine care	70% of Maximum Allowance for Eligible Expenses (after deductible)

	Enhanced Health Savings Account (HSA)	
Feature	**Network**	**Out-of-Network (Maximum Allowance Limits Apply)***
Maximum Benefits	**Plan Pays Benefits For ...**	
▪ Well-Man Care (prostate-specific antigen [PSA]/digital rectal exam [DRE])	No limit on routine care	70% of Maximum Allowance for Eligible Expenses (after deductible)
▪ Colorectal Cancer Screenings	No limit on routine care	70% of Maximum Allowance for Eligible Expenses (after deductible)
▪ Routine Eye Exams	One Exam Every 24 Months	
▪ Routine Hearing Exams	One Exam Every 24 Months	
▪ Hearing Aids Congenital Defects Only	**Covered to Age 19:** Hearing aids are subject to deductible and coinsurance (limited to one per ear per year).	

Types of Covered Services

Here is a snapshot of the types of services the Plan covers under this option. The services listed are further detailed under the “What the Plan Covers” main section. You're also eligible for prescription drug coverage. See “The CVS Caremark Prescription Drug Program for the Blue Cross Blue Shield National Coverage Options” main section for details.

The benefits outlined below are generally covered as shown, but cost-sharing is based upon the type and place of treatment as well as facility billing practices.

Type of Service	Enhanced HSA			
	Network*		Out-of-Network (Maximum Allowance Limits Apply)*	
	You Pay (Annual Deductible)	Plan Pays (Coinsurance)**	You Pay (Annual Deductible)	Plan Pays (Coinsurance)**
Inpatient Services (preauthorization required; see "The Managed Care Program" main section)				
▪ Room and Board and Miscellaneous Hospital Expenses	$1,500/$2,700/$3,000	90% of Negotiated Fees (after deductible)	$3,000/$5,400/$6,000	70% of Maximum Allowance (after deductible)
▪ Physician Services While Hospitalized	$1,500/$2,700/$3,000	90% of Negotiated Fees (after deductible)	$3,000/$5,400/$6,000	70% of Maximum Allowance (after deductible)
▪ Routine Nursery Care	$1,500/$2,700/$3,000	90% of Negotiated Fees (after deductible)	$3,000/$5,400/$6,000	70% of Maximum Allowance (after deductible)
▪ Prescription Drugs While Hospitalized and Other Inpatient Care	$1,500/$2,700/$3,000	90% of Negotiated Fees (after deductible)	$3,000/$5,400/$6,000	70% of Maximum Allowance (after deductible)
Alternatives to Inpatient Hospital Care (preauthorization required; see "The Managed Care Program" main section)				
▪ Coordinated Home Health or Skilled Nursing Care	$1,500/$2,700/$3,000	90% of Negotiated Fees (after deductible)	$3,000/$5,400/$6,000	70% of Maximum Allowance (after deductible)
▪ Private Duty Nursing Care	$1,500/$2,700/$3,000	90% of Negotiated Fees (after deductible)	$3,000/$5,400/$6,000	70% of Maximum Allowance (after deductible)
▪ Hospice Care	$1,500/$2,700/$3,000	90% of Negotiated Fees (after deductible)	$3,000/$5,400/$6,000	70% of Maximum Allowance (after deductible)

* When paying benefits, the Plan considers whether or not a service is *medically necessary*. It also considers the *negotiated fee* (applies for *network care*), whether the charge is the *maximum allowance* (applies for *out-of-network care*), and whether you have coverage from other sources. See the "Coordination of Benefits (COB)" main section for details. You're responsible for any charge that exceeds the *maximum allowance* amount when you receive *out-of-network care, unless you* receive emergency care or services from a radiologist, anesthesiologist or pathologist while hospitalized and you have no choice in *provider*. Contact the *claims administrator* for more information.

** All percentages shown are percentages of either the *negotiated fee* or *maximum allowance* charge for the *eligible expense*.

Type of Service	Enhanced HSA			
	Network*		Out-of-Network (Maximum Allowance Limits Apply)*	
	You Pay (Annual Deductible)	Plan Pays (Coinsurance)**	You Pay (Annual Deductible)	Plan Pays (Coinsurance)**
Outpatient Services (preauthorization required; see "The Managed Care Program" main section)				
▪ Hospital Facility Expenses	$1,500/$2,700/$3,000	90% of Negotiated Fees (after deductible)	$3,000/$5,400/$6,000	70% of Maximum Allowance (after deductible)
▪ Hospice Care	$1,500/$2,700/$3,000	90% of Negotiated Fees (after deductible)	$3,000/$5,400/$6,000	70% of Maximum Allowance (after deductible)
Surgical Expenses (preauthorization required for inpatient expenses; see "The Managed Care Program" main section)				
▪ Inpatient and Outpatient Surgical Expenses (outside an office setting)	$1,500/$2,700/$3,000	90% of Negotiated Fees (after deductible)	$3,000/$5,400/$6,000	70% of Maximum Allowance (after deductible)
▪ Outpatient Surgical Expenses (surgeon's charges and office visits)	$1,500/$2,700/$3,000	90% of Negotiated Fees (after deductible)	$3,000/$5,400/$6,000	70% of Maximum Allowance (after deductible)
▪ Oral Surgical Procedures (when medical in nature only, impacted teeth not covered)	$1,500/$2,700/$3,000	90% of Negotiated Fees (after deductible)	$3,000/$5,400/$6,000	70% of Maximum Allowance (after deductible)
▪ Second Surgical Opinions	$1,500/$2,700/$3,000	90% of Negotiated Fees (after deductible)	$3,000/$5,400/$6,000	70% of Maximum Allowance (after deductible)
▪ Preoperative Testing	$1,500/$2,700/$3,000	90% of Negotiated Fees (after deductible)	$3,000/$5,400/$6,000	70% of Maximum Allowance (after deductible)

* When paying benefits, the Plan considers whether or not a service is *medically necessary*. It also considers the *negotiated fee* (applies for *network care*), whether the charge is the *maximum allowance* (applies for *out-of-network care*), and whether you have coverage from other sources. See the "Coordination of Benefits (COB)" main section for details. You're responsible for any charge that exceeds the *maximum allowance* amount when you receive *out-of-network care, unless you* receive emergency care or services from a radiologist, anesthesiologist or pathologist while hospitalized and you have no choice in *provider*. Contact the *claims administrator* for more information.

** All percentages shown are percentages of either the *negotiated fee* or *maximum allowance* charge for the *eligible expense*.

Type of Service	Enhanced HSA			
	Network*		Out-of-Network (Maximum Allowance Limits Apply)*	
	You Pay (Annual Deductible)	Plan Pays (Coinsurance)**	You Pay (Annual Deductible)	Plan Pays (Coinsurance)**
Emergency Medical Care Services				
▪ Hospital Emergency Room	$1,500/$2,700/$3,000	90% of Negotiated Fees (after deductible) If a True Emergency Non-Emergency Use Not Covered	$3,000/$5,400/$6,000	90% of Maximum Allowance (after deductible) If a True Emergency Non-emergency Use Not Covered
▪ Urgent Care Facility	$1,500/$2,700/$3,000	90% of Negotiated Fees If a True Emergency Non-Emergency Use Not Covered	$3,000/$5,400/$6,000	70% of Maximum Allowance (after deductible) If a True Emergency Non-Emergency Use Not Covered
▪ Ambulance Services	$1,500/$2,700/$3,000	90% of Negotiated Fees (after deductible) If a True Emergency Non-Emergency Use Not Covered	$3,000/$5,400/$6,000	90% of Maximum Allowance (after deductible) If a True Emergency Non-Emergency Use Not Covered
Professional Services				
▪ Physician Office Visits	$1,500/$2,700/$3,000	90% of Negotiated Fees (after deductible)	$3,000/$5,400/$6,000	70% of Maximum Allowance (after deductible)
▪ Specialist Office Visits/Consultations	$1,500/$2,700/$3,000	90% of Negotiated Fees (after deductible)	$3,000/$5,400/$6,000	70% of Maximum Allowance (after deductible)
▪ MDLive Telehealth Virtual Visit	$1,500/$2,700/$3,000	90% of Negotiated Fees (after deductible)	NA	NA
▪ Office Visit Associated with Allergy Testing (if not billed as preventive)	$1,500/$2,700/$3,000	90% of Negotiated Fees (after deductible)	$3,000/$5,400/$6,000	70% of Maximum Allowance (after deductible)

Type of Service	Enhanced HSA			
	Network*		Out-of-Network (Maximum Allowance Limits Apply)*	
	You Pay (Annual Deductible)	Plan Pays (Coinsurance)**	You Pay (Annual Deductible)	Plan Pays (Coinsurance)**
Diagnostic Procedures				
▪ Services Performed by a Radiologist, Anesthesiologist, or Pathologist	$1,500/$2,700/$3,000	90% of Negotiated Fees (after deductible)	$3,000/$5,400/$6,000	70% of Maximum Allowance (after deductible)
▪ Diagnostic X-Ray and Lab Tests (performed as part of an office visit and billed by a physician)	$1,500/$2,700/$3,000	90% of Negotiated Fees (after deductible)	$3,000/$5,400/$6,000	70% of Maximum Allowance (after deductible)
▪ Outpatient Diagnostic X-Ray and Lab Tests (performed in an outpatient hospital or other outpatient facility/setting/independent lab and billed by a lab or clinic)	$1,500/$2,700/$3,000	90% of Negotiated Fees (after deductible)	$3,000/$5,400/$6,000	70% of Maximum Allowance (after deductible)
▪ Complex Imaging Services (MRA/MRS, MRI, CT scans, PET scans; **preauthorization required, see "The Managed Care Program" main section**)	$1,500/$2,700/$3,000	90% of Negotiated Fees (after deductible)	$3,000/$5,400/$6,000	70% of Maximum Allowance (after deductible)

* When paying benefits, the Plan considers whether or not a service is *medically necessary*. It also considers the *negotiated fee* (applies for *network care*), whether the charge is the *maximum allowance* (applies for *out-of-network care*), and whether you have coverage from other sources. See the "Coordination of Benefits (COB)" main section for details. You're responsible for any charge that exceeds the *maximum allowance* amount when you receive *out-of-network care, unless you* receive emergency care or services from a radiologist, anesthesiologist or pathologist while hospitalized and you have no choice in *provider*. Contact the *claims administrator* for more information.

** All percentages shown are percentages of either the *negotiated fee* or *maximum allowance* charge for the *eligible expense*.

Type of Service	Enhanced HSA			
	Network*		Out-of-Network (Maximum Allowance Limits Apply)*	
	You Pay (Annual Deductible)	Plan Pays (Coinsurance)**	You Pay (Annual Deductible)	Plan Pays (Coinsurance)**
Outpatient Therapy				
▪ Short-Term Rehabilitation Physician's Services	$1,500/$2,700/$3,000	90% of Negotiated Fees (after deductible)	$3,000/$5,400/$6,000	70% of Maximum Allowance (after deductible)
▪ Short-Term Rehabilitation Services of a Physical, Speech, or Occupational Therapist	$1,500/$2,700/$3,000	90% of Negotiated Fees (after deductible)	$3,000/$5,400/$6,000	70% of Maximum Allowance (after deductible)
▪ Treatment of Spinal Disorders	$1,500/$2,700/$3,000	90% of Negotiated Fees (after deductible)	$3,000/$5,400/$6,000	70% of Maximum Allowance (after deductible)
▪ Infusion Therapy Performed in the Home, Office, or Outpatient Facility	$1,500/$2,700/$3,000	90% of Negotiated Fees (after deductible)	$3,000/$5,400/$6,000	70% of Maximum Allowance (after deductible)
▪ Cardiac/Pulmonary Rehabilitation Therapy (based on medical necessity)	$1,500/$2,700/$3,000	90% of Negotiated Fees (after deductible)	$3,000/$5,400/$6,000	70% of Maximum Allowance (after deductible)
Maternity—Prenatal and Postnatal Care (preauthorization required; see "The Managed Care Program" main section)				
▪ Initial Visit to Confirm Pregnancy	$1,500/$2,700/$3,000	90% of Negotiated Fees (after deductible)	$3,000/$5,400/$6,000	70% of Maximum Allowance (after deductible)
▪ All Subsequent Prenatal and Postnatal Visits	$1,500/$2,700/$3,000	90% of Negotiated Fees (after deductible)	$3,000/$5,400/$6,000	70% of Maximum Allowance (after deductible)

* When paying benefits, the Plan considers whether or not a service is *medically necessary*. It also considers the *negotiated fee* (applies for *network care*), whether the charge is the *maximum allowance* (applies for *out-of-network care*), and whether you have coverage from other sources. See the "Coordination of Benefits (COB)" main section for details. You're responsible for any charge that exceeds the *maximum allowance* amount when you receive *out-of-network care, unless you* receive emergency care or services from a radiologist, anesthesiologist or pathologist while hospitalized and you have no choice in *provider*. Contact the *claims administrator* for more information.

** All percentages shown are percentages of either the *negotiated fee* or *maximum allowance* charge for the *eligible expense*.

Type of Service	Enhanced HSA			
	Network*		Out-of-Network (Maximum Allowance Limits Apply)*	
	You Pay (Annual Deductible)	Plan Pays (Coinsurance)**	You Pay (Annual Deductible)	Plan Pays (Coinsurance)**
▪ Delivery Charges (including inpatient hospital routine nursery care)	$1,500/$2,700/$3,000	90% of Negotiated Fees (after deductible)	$3,000/$5,400/$6,000	70% of Maximum Allowance (after deductible)
▪ Free-Standing Birthing Centers	$1,500/$2,700/$3,000	90% of Negotiated Fees (after deductible)	$3,000/$5,400/$6,000	70% of Maximum Allowance (after deductible)
Family Planning				
▪ Infertility Treatments (including the diagnosis and treatment of the underlying cause of infertility only)	$1,500/$2,700/$3,000	90% of Negotiated Fees (after deductible)	$3,000/$5,400/$6,000	70% of Maximum Allowance (after deductible)
▪ Office Visit Associated with Contraceptives, Implants, Devices, and Injectables	$1,500/$2,700/$3,000	90% of Negotiated Fees (after deductible)	$3,000/$5,400/$6,000	70% of Maximum Allowance (after deductible)
▪ Voluntary Abortions	$1,500/$2,700/$3,000	90% of Negotiated Fees (after deductible)	$3,000/$5,400/$6,000	70% of Maximum Allowance (after deductible)
▪ Voluntary Sterilization	$1,500/$2,700/$3,000	90% of Negotiated Fees (after deductible)	$3,000/$5,400/$6,000	70% of Maximum Allowance (after deductible)
Preventive Care (age and frequency limits apply). Must be billed as preventive.				
▪ Well-Child Care (including routine immunizations and flu shots)	None (does not apply to HSA)	100% of Negotiated Fees (no deductible)	$3,000/$5,400/$6,000	70% of Maximum Allowance (after deductible)
▪ Adult Routine Physical Exams (including routine immunizations and flu shots)	None (does not apply to HSA)	100% of Negotiated Fees (no deductible)	$3,000/$5,400/$6,000	70% of Maximum Allowance (after deductible)
▪ Well-Woman Care (including routine GYN exam and Pap smear)	None (does not apply to HSA)	100% of Negotiated Fees (no deductible)	$3,000/$5,400/$6,000	70% of Maximum Allowance (after deductible)

Type of Service	Enhanced HSA			
	Network*		Out-of-Network (Maximum Allowance Limits Apply)*	
	You Pay (Annual Deductible)	Plan Pays (Coinsurance)**	You Pay (Annual Deductible)	Plan Pays (Coinsurance)**
▪ Routine Mammograms	None (does not apply to HSA)	100% of Negotiated Fees (no deductible)	$3,000/$5,400/$6,000	70% of Maximum Allowance (after deductible)
▪ Well-Man Care (prostate-specific antigen [PSA]/digital rectal exam [DRE])	None (does not apply to HSA)	100% of Negotiated Fees (no deductible)	$3,000/$5,400/$6,000	70% of Maximum Allowance (after deductible)
▪ Eye Exams (routine only) Vision eyewear benefit is through Blue Cross Blue Shield Vision Discount Program	None (does not apply to HSA)	100% of Negotiated Fees (no deductible)	$3,000/$5,400/$6,000	70% of Maximum Allowance (after deductible)
▪ Hearing Exams (routine only)	None (does not apply to HSA)	100% of Negotiated Fees (no deductible)	$3,000/$5,400/$6,000	70% of Maximum Allowance (after deductible)
▪ Routine Wellness Screenings	None (does not apply to HSA)	100% of Negotiated Fees (no deductible)	$3,000/$5,400/$6,000	70% of Maximum Allowance (after deductible)
Other Covered Services				
▪ Acupuncture in Lieu of Anesthesia Only	$1,500/$2,700/$3,000	90% of Negotiated Fees (after deductible)	$3,000/$5,400/$6,000	70% of Maximum Allowance (after deductible)
▪ Allergy Treatments/ Injections (received outside of office visit or not received by a physician)	$1,500/$2,700/$3,000	90% of Negotiated Fees (after deductible) (unless office visit charge is waived)	$3,000/$5,400/$6,000	70% of Maximum Allowance (after deductible)
▪ Anesthetics	$1,500/$2,700/$3,000	90% of Negotiated Fees (after deductible)	$3,000/$5,400/$6,000	70% of Maximum Allowance (after deductible)

Type of Service	Enhanced HSA			
	Network*		Out-of-Network (Maximum Allowance Limits Apply)*	
	You Pay (Annual Deductible)	Plan Pays (Coinsurance)**	You Pay (Annual Deductible)	Plan Pays (Coinsurance)**
▪ Bariatric Surgery (through Blue Distinction Centers only; **preauthorization required; see "The Managed Care Program" main section**)	$1,500/$2,700/$3,000	100% of Negotiated Fees (after deductible) Benefits also may be payable for travel and lodging expenses.	Not Covered	Not Covered
▪ Dental Services (medical in nature only, impacted teeth not covered)	$1,500/$2,700/$3,000	90% of Negotiated Fees (after deductible)	$3,000/$5,400/$6,000	70% of Maximum Allowance (after deductible)
▪ Drugs and Medications (prescribed during an inpatient stay)	$1,500/$2,700/$3,000	90% of Negotiated Fees (after deductible)	$3,000/$5,400/$6,000	70% of Maximum Allowance (after deductible)
▪ Durable Medical and Surgical Equipment/ Prosthetics	$1,500/$2,700/$3,000	90% of Negotiated Fees (after deductible)	$3,000/$5,400/$6,000	70% of Maximum Allowance (after deductible)
▪ Hearing Aids for Children with Congenital Defects, Up to Age 19	$1,500/$2,700/$3,000	90% of Negotiated Fees (after deductible)	$3,000/$5,400/$6,000	70% of Maximum Allowance (after deductible)
▪ Mastectomy Services	$1,500/$2,700/$3,000	90% of Negotiated Fees (after deductible)	$3,000/$5,400/$6,000	70% of Maximum Allowance (after deductible)
▪ Transplant Services (coordination by patient with transplant coordinator; Blue Distinction Center is required)	$1,500/$2,700/$3,000	100% of Negotiated Fees (after deductible) at Blue Distinction Center	Not Covered	Not Covered
▪ Diabetic foot orthotics	$1,500/$2,700/$3,000	90% of Negotiated Fees (after deductible)	$3,000/$5,400/$6,000	70% of Maximum Allowance (after deductible)

Type of Service	Enhanced HSA			
	Network*		Out-of-Network (Maximum Allowance Limits Apply)*	
	You Pay (Annual Deductible)	Plan Pays (Coinsurance)**	You Pay (Annual Deductible)	Plan Pays (Coinsurance)**
Behavioral Health and Substance Abuse Treatments (preauthorization required; see "The Managed Care Program" main section)				
▪ Inpatient (including a residential treatment facility)	$1,500/$2,700/$3,000	90% of Negotiated Fees (after deductible)	$3,000/$5,400/$6,000	70% of Maximum Allowance (after deductible)
▪ Outpatient (including partial hospitalization)	$1,500/$2,700/$3,000	90% of Negotiated Fees (after deductible)	$3,000/$5,400/$6,000	70% of Maximum Allowance (after deductible)

The Plan considers your expense incurred on the day you receive the service or supply. It doesn't pay benefits for any expense you incur before coverage begins or after coverage ends (even if the expense is due to an *accident*, *injury*, or *illness* that occurs while your coverage is in effect).

A Snapshot of Your Core HSA Coverage

HSA, Deductibles, Coinsurance, Out-of-Pocket Maximums, and Maximum Benefits

Here is a snapshot of the health reimbursement account contribution, annual *deductibles*, *coinsurance*, annual out-of-pocket maximums, and maximum benefits that apply under the Core HSA coverage option. Many of these terms are defined under the "How Your Coverage Works" main section.

	Core Health Savings Account (HSA)	
Feature	**Network**	**Out-of-Network (Maximum Allowance Limits Apply)***
Annual Health Savings Account (HSA) Company Contribution	**Company Contributes (contributions may be made quarterly but no later than semi-annually)**	
▪ Employee Only	$500	
▪ Employee + Spouse or Employee + Child(ren)	$750	
▪ Family	$1,000	
Annual Health Savings Account (HSA) Employee Maximum Contribution	**You May Contribute Up to...**	
▪ Employee Only	$3,000	
▪ Employee + Spouse or Employee + Child(ren)	$6,250	
▪ Family	$6,000	

* The Plan pays benefits for *eligible expenses*. For *out-of-network care*, *eligible expenses* are based on the *maximum allowance*. You're responsible for any charge that exceeds the *maximum allowance*.

	Core Health Savings Account (HSA)	
Feature	**Network**	**Out-of-Network (Maximum Allowance Limits Apply)***
	You Pay	**You Pay**
Annual Deductible (HSA is included in deductible amount)		
▪ Employee Only	$4,500	$9,000
▪ Employee + Spouse or Employee + Child(ren)[±]	$6,750	$13,500
▪ Family[±]	$9,000	$18,000
Annual Out-of-Pocket Maximum (includes deductible; includes network/out-of-network providers)		
▪ Employee Only	$6,000	$12,000
▪ Employee + Spouse or Employee + Child(ren)[±±]	$12,000	$24,000
▪ Family[**]	$12,000	$24,000
	Plan Pays	**Plan Pays**
Coinsurance	Generally, 70% of Negotiated Fees for Eligible Expenses (after deductible)	Generally, 50% of Maximum Allowance for Eligible Expenses (after deductible)
▪ Blue Distinction Centers required for transplants and bariatric; optional for knee/hip replacement, spine, cardiac care, and rare cancers, but provides a higher level of benefit	80% after deductible Benefits also may be payable for travel and lodging expenses.	No coverage
Lifetime Maximum Benefit	No Limit	

[±] Once one individual's eligible expenses reach the plan's individual deductible, the plan will start paying the coinsurance for eligible claims for that individual. For any remaining covered family members, their eligible expenses will apply to meeting the remaining in-network deductible and out-of-pocket maximum for the tier of coverage selected..

[±±] If an individual's eligible expenses reach the individual out-of-pocket maximum, eligible expenses will be paid at 100% for the remainder of the plan year for that individual For any remaining covered family members, their eligible expenses will apply to meeting the remaining out-of-pocket maximum for the tier of coverage selected.

	Core Health Savings Account (HSA)	
Feature	**Network**	**Out-of-Network (Maximum Allowance Limits Apply)***
Maximum Benefits	**Plan Pays Benefits For ...**	
▪ Coordinated Home Health Care or Skilled Nursing	Up to 120 Visits Per Calendar Year (applies to all combined covered network and out-of-network services)	
▪ Private Duty Nursing Care	Up to 70 Days Per Calendar Year	
▪ Outpatient Short-Term Rehabilitation (physical, occupational, and speech therapy)	Up to 60 Combined Visits Per Calendar Year (applies to all combined covered network and out-of-network services; limitations may apply)	
▪ Spinal Disorders (spinal manipulations performed by an M.D., D.O., chiropractor, or therapist)	Up to 60 Visits Per Calendar Year (applies to all combined covered network and out-of-network services, limitations may apply, subject to review at 20 visits)	
▪ Family Planning	Limited to the diagnosis and treatment of the underlying cause of infertility only	
▪ Transplant Services (coordination by patient with transplant coordinator; Blue Distinction Center is required)	Requires preauthorization and use of **claims administrator-approved Human Organ Transplant Programs** required to receive benefits. Benefits also are payable for travel and lodging expenses.	
▪ Well-Child Care (includes routine immunizations, travel immunizations, and flu shots)	No limit on routine care	50% of Maximum Allowance for Eligible Expenses (after deductible)
▪ Adult Routine Physical Exams (includes routine immunizations and flu shots)	No limit on routine care	50% of Maximum Allowance for Eligible Expenses (after deductible)
▪ Well-Woman Care	No limit on routine care	50% of Maximum Allowance for Eligible Expenses (after deductible)

	Core Health Savings Account (HSA)	
Feature	**Network**	**Out-of-Network (Maximum Allowance Limits Apply)***
Maximum Benefits	**Plan Pays Benefits For ...**	
▪ Routine Mammograms	No limit on routine care	50% of Maximum Allowance for Eligible Expenses (after deductible)
▪ Well-Man Care (prostate-specific antigen [PSA]/digital rectal exam [DRE])	No limit on routine care	50% of Maximum Allowance for Eligible Expenses (after deductible)
▪ Colorectal Cancer Screenings	No limit on routine care	50% of Maximum Allowance for Eligible Expenses (after deductible)
▪ Routine Eye Exams	One Exam Every 24 Months	
▪ Routine Hearing Exams	One Exam Every 24 Months	
▪ Hearing Aids Congenital Defects Only	**Covered to Age 19:** Hearing aids are subject to deductible and coinsurance (limited to one per ear per year).	

Types of Covered Services

Here is a snapshot of the types of services the Plan covers under this option. The services listed are further detailed under the “What the Plan Covers” main section. You're also eligible for prescription drug coverage. See “The CVS Caremark Prescription Drug Program for the Blue Cross Blue Shield National Coverage Options” main section for details.

The benefits outlined below are generally covered as shown, but cost-sharing is based upon the type and place of treatment as well as facility billing practices.

Type of Service	Core HSA			
	Network*		Out-of-Network (Maximum Allowance Limits Apply)*	
	You Pay (Annual Deductible)	Plan Pays (Coinsurance)**	You Pay (Annual Deductible)	Plan Pays (Coinsurance)**
Inpatient Services (preauthorization required; see "The Managed Care Program" main section)				
▪ Room and Board and Miscellaneous Hospital Expenses	$4,500/$6,750/$9,000	70% of Negotiated Fees (after deductible)	$9,000/$13,500/$18,000	50% of Maximum Allowance (after deductible)
▪ Physician Services While Hospitalized	$4,500/$6,750/$9,000	70% of Negotiated Fees (after deductible)	$9,000/$13,500/$18,000	50% of Maximum Allowance (after deductible)
▪ Routine Nursery Care	$4,500/$6,750/$9,000	70% of Negotiated Fees (after deductible)	$9,000/$13,500/$18,000	50% of Maximum Allowance (after deductible)
▪ Prescription Drugs While Hospitalized and Other Inpatient Care	$4,500/$6,750/$9,000	70% of Negotiated Fees (after deductible)	$9,000/$13,500/$18,000	50% of Maximum Allowance (after deductible)
Alternatives to Inpatient Hospital Care (preauthorization required; see "The Managed Care Program" main section)				
▪ Coordinated Home Health or Skilled Nursing Care	$4,500/$6,750/$9,000	70% of Negotiated Fees (after deductible)	$9,000/$13,500/$18,000	50% of Maximum Allowance (after deductible)
▪ Private Duty Nursing Care	$4,500/$6,750/$9,000	70% of Negotiated Fees (after deductible)	$9,000/$13,500/$18,000	50% of Maximum Allowance (after deductible)
▪ Hospice Care	$4,500/$6,750/$9,000	70% of Negotiated Fees (after deductible)	$9,000/$13,500/$18,000	50% of Maximum Allowance (after deductible)

* When paying benefits, the Plan considers whether or not a service is *medically necessary*. It also considers the *negotiated fee* (applies for *network care*), whether the charge is the *maximum allowance* (applies for *out-of-network care*), and whether you have coverage from other sources. See the "Coordination of Benefits (COB)" main section for details. You're responsible for any charge that exceeds the *maximum allowance* amount when you receive *out-of-network care, unless you* receive emergency care or services from a radiologist, anesthesiologist or pathologist while hospitalized and you have no choice in *provider*. Contact the *claims administrator* for more information.

** All percentages shown are percentages of either the *negotiated fee* or *maximum allowance* charge for the *eligible expense*.

Type of Service	Core HSA			
	Network*		Out-of-Network (Maximum Allowance Limits Apply)*	
	You Pay (Annual Deductible)	Plan Pays (Coinsurance)**	You Pay (Annual Deductible)	Plan Pays (Coinsurance)**
Outpatient Services (preauthorization required; see "The Managed Care Program" main section)				
▪ Hospital Facility Expenses	$4,500/$6,750/$9,000	70% of Negotiated Fees (after deductible)	$9,000/$13,500/$18,000	50% of Maximum Allowance (after deductible)
▪ Hospice Care	$4,500/$6,750/$9,000	70% of Negotiated Fees (after deductible)	$9,000/$13,500/$18,000	50% of Maximum Allowance (after deductible)
Surgical Expenses (preauthorization required for inpatient expenses; see "The Managed Care Program" main section)				
▪ Inpatient and Outpatient Surgical Expenses (outside an office setting)	$4,500/$6,750/$9,000	70% of Negotiated Fees (after deductible)	$9,000/$13,500/$18,000	50% of Maximum Allowance (after deductible)
▪ Outpatient Surgical Expenses (surgeon's charges and office visits)	$4,500/$6,750/$9,000	70% of Negotiated Fees (after deductible)	$9,000/$13,500/$18,000	50% of Maximum Allowance (after deductible)
▪ Oral Surgical Procedures (when medical in nature only, impacted teeth not covered)	$4,500/$6,750/$9,000	70% of Negotiated Fees (after deductible)	$9,000/$13,500/$18,000	50% of Maximum Allowance (after deductible)
▪ Second Surgical Opinions	$4,500/$6,750/$9,000	70% of Negotiated Fees (after deductible)	$9,000/$13,500/$18,000	50% of Maximum Allowance (after deductible)
▪ Preoperative Testing	$4,500/$6,750/$9,000	70% of Negotiated Fees (after deductible)	$9,000/$13,500/$18,000	50% of Maximum Allowance (after deductible)

* When paying benefits, the Plan considers whether or not a service is *medically necessary*. It also considers the *negotiated fee* (applies for *network care*), whether the charge is the *maximum allowance* (applies for *out-of-network care*), and whether you have coverage from other sources. See the "Coordination of Benefits (COB)" main section for details. You're responsible for any charge that exceeds the *maximum allowance* amount when you receive *out-of-network care, unless you* receive emergency care or services from a radiologist, anesthesiologist or pathologist while hospitalized and you have no choice in *provider*. Contact the *claims administrator* for more information.

** All percentages shown are percentages of either the *negotiated fee* or *maximum allowance* charge for the *eligible expense*.

Type of Service	Core HSA			
	Network*		Out-of-Network (Maximum Allowance Limits Apply)*	
	You Pay (Annual Deductible)	Plan Pays (Coinsurance)**	You Pay (Annual Deductible)	Plan Pays (Coinsurance)**
Emergency Medical Care Services				
▪ Hospital Emergency Room	$4,500/$6,750/$9,000	70% of Negotiated Fees (after deductible) If a True Emergency Non-Emergency Use Not Covered	$9,000/$13,500/$18,000	70% of Maximum Allowance (after deductible) If a True Emergency Non-emergency Use Not Covered
▪ Urgent Care Facility	$4,500/$6,750/$9,000	70% of Negotiated Fees If a True Emergency Non-Emergency Use Not Covered	$9,000/$13,500/$18,000	50% of Maximum Allowance (after deductible) If a True Emergency Non-Emergency Use Not Covered
▪ Ambulance Services	$4,500/$6,750/$9,000	70% of Negotiated Fees (after deductible) If a True Emergency Non-Emergency Use Not Covered	$9,000/$13,500/$18,000	70% of Maximum Allowance (after deductible) If a True Emergency Non-Emergency Use Not Covered
Professional Services				
▪ Physician Office Visits	$4,500/$6,750/$9,000	70% of Negotiated Fees (after deductible)	$9,000/$13,500/$18,000	50% of Maximum Allowance (after deductible)
▪ Specialist Office Visits/Consultations	$4,500/$6,750/$9,000	70% of Negotiated Fees (after deductible)	$9,000/$13,500/$18,000	50% of Maximum Allowance (after deductible)
▪ MDLive Telehealth Virtual Visit	$4,500/$6,750/$9,000	70% of Negotiated Fees (after deductible)	NA	NA
▪ Office Visit Associated with Allergy Testing if not billed as preventive)	$4,500/$6,750/$9,000	70% of Negotiated Fees (after deductible)	$9,000/$13,500/$18,000	50% of Maximum Allowance (after deductible)

Type of Service	Core HSA			
	Network*		Out-of-Network (Maximum Allowance Limits Apply)*	
	You Pay (Annual Deductible)	Plan Pays (Coinsurance)**	You Pay (Annual Deductible)	Plan Pays (Coinsurance)**
Diagnostic Procedures				
▪ Services Performed by a Radiologist, Anesthesiologist, or Pathologist	$4,500/$6,750/$9,000	70% of Negotiated Fees (after deductible)	$9,000/$13,500/$18,000	50% of Maximum Allowance (after deductible)
▪ Diagnostic X-Ray and Lab Tests (performed as part of an office visit and billed by a physician)	$4,500/$6,750/$9,000	70% of Negotiated Fees (after deductible)	$9,000/$13,500/$18,000	50% of Maximum Allowance (after deductible)
▪ Outpatient Diagnostic X-Ray and Lab Tests (performed in an outpatient hospital or other outpatient facility/setting/independent lab and billed by a lab or clinic)	$4,500/$6,750/$9,000	70% of Negotiated Fees (after deductible)	$9,000/$13,500/$18,000	50% of Maximum Allowance (after deductible)
▪ Complex Imaging Services (MRA/MRS, MRI, CT scans, PET scans; **preauthorization required, see "The Managed Care Program" main section**)	$4,500/$6,750/$9,000	70% of Negotiated Fees (after deductible)	$9,000/$13,500/$18,000	50% of Maximum Allowance (after deductible)

* When paying benefits, the Plan considers whether or not a service is *medically necessary*. It also considers the *negotiated fee* (applies for *network care*), whether the charge is the *maximum allowance* (applies for *out-of-network care*), and whether you have coverage from other sources. See the "Coordination of Benefits (COB)" main section for details. You're responsible for any charge that exceeds the *maximum allowance* amount when you receive *out-of-network care, unless you* receive emergency care or services from a radiologist, anesthesiologist or pathologist while hospitalized and you have no choice in *provider*. Contact the *claims administrator* for more information.

** All percentages shown are percentages of either the *negotiated fee* or *maximum allowance* charge for the *eligible expense*.

Type of Service	Core HSA			
	Network*		Out-of-Network (Maximum Allowance Limits Apply)*	
	You Pay (Annual Deductible)	Plan Pays (Coinsurance)**	You Pay (Annual Deductible)	Plan Pays (Coinsurance)**
Outpatient Therapy				
▪ Short-Term Rehabilitation Physician's Services	$4,500/$6,750/$9,000	70% of Negotiated Fees (after deductible)	$9,000/$13,500/$18,000	50% of Maximum Allowance (after deductible)
▪ Short-Term Rehabilitation Services of a Physical, Speech, or Occupational Therapist	$4,500/$6,750/$9,000	70% of Negotiated Fees (after deductible)	$9,000/$13,500/$18,000	50% of Maximum Allowance (after deductible)
▪ Treatment of Spinal Disorders	$4,500/$6,750/$9,000	70% of Negotiated Fees (after deductible)	$9,000/$13,500/$18,000	50% of Maximum Allowance (after deductible)
▪ Infusion Therapy Performed in the Home, Office, or Outpatient Facility	$4,500/$6,750/$9,000	70% of Negotiated Fees (after deductible)	$9,000/$13,500/$18,000	50% of Maximum Allowance (after deductible)
▪ Cardiac/Pulmonary Rehabilitation Therapy (based on medical necessity)	$4,500/$6,750/$9,000	70% of Negotiated Fees (after deductible)	$9,000/$13,500/$18,000	50% of Maximum Allowance (after deductible)
Maternity—Prenatal and Postnatal Care (preauthorization required; see "The Managed Care Program" main section)				
▪ Initial Visit to Confirm Pregnancy	$4,500/$6,750/$9,000	70% of Negotiated Fees (after deductible)	$9,000/$13,500/$18,000	50% of Maximum Allowance (after deductible)
▪ All Subsequent Prenatal and Postnatal Visits	$4,500/$6,750/$9,000	70% of Negotiated Fees (after deductible)	$9,000/$13,500/$18,000	50% of Maximum Allowance (after deductible)

* When paying benefits, the Plan considers whether or not a service is *medically necessary*. It also considers the *negotiated fee* (applies for *network care*), whether the charge is the *maximum allowance* (applies for *out-of-network care*), and whether you have coverage from other sources. See the "Coordination of Benefits (COB)" main section for details. You're responsible for any charge that exceeds the *maximum allowance* amount when you receive *out-of-network care, unless you* receive emergency care or services from a radiologist, anesthesiologist or pathologist while hospitalized and you have no choice in *provider*. Contact the *claims administrator* for more information.

** All percentages shown are percentages of either the *negotiated fee* or *maximum allowance* charge for the *eligible expense*.

Type of Service	Core HSA			
	Network*		Out-of-Network (Maximum Allowance Limits Apply)*	
	You Pay (Annual Deductible)	Plan Pays (Coinsurance)**	You Pay (Annual Deductible)	Plan Pays (Coinsurance)**
▪ Delivery Charges (including inpatient hospital routine nursery care)	$4,500/$6,750/$9,000	70% of Negotiated Fees (after deductible)	$9,000/$13,500/$18,000	50% of Maximum Allowance (after deductible)
▪ Free-Standing Birthing Centers	$4,500/$6,750/$9,000	70% of Negotiated Fees (after deductible)	$9,000/$13,500/$18,000	50% of Maximum Allowance (after deductible)
Family Planning				
▪ Infertility Treatments (including the diagnosis and treatment of the underlying cause of infertility only)	$4,500/$6,750/$9,000	70% of Negotiated Fees (after deductible)	$9,000/$13,500/$18,000	50% of Maximum Allowance (after deductible)
▪ Office Visit Associated with Contraceptives, Implants, Devices, and Injectables	$4,500/$6,750/$9,000	70% of Negotiated Fees (after deductible)	$9,000/$13,500/$18,000	50% of Maximum Allowance (after deductible)
▪ Voluntary Abortions	$4,500/$6,750/$9,000	70% of Negotiated Fees (after deductible)	$9,000/$13,500/$18,000	50% of Maximum Allowance (after deductible)
▪ Voluntary Sterilization	$4,500/$6,750/$9,000	70% of Negotiated Fees (after deductible)	$9,000/$13,500/$18,000	50% of Maximum Allowance (after deductible)
Preventive Care (age and frequency limits apply). Must be billed as preventive.				
▪ Well-Child Care (including routine immunizations and flu shots)	None (does not apply to HSA)	100% of Negotiated Fees (no deductible)	$9,000/$13,500/$18,000	50% of Maximum Allowance (after deductible)
▪ Adult Routine Physical Exams (including routine immunizations and flu shots)	None (does not apply to HSA)	100% of Negotiated Fees (no deductible)	$9,000/$13,500/$18,000	50% of Maximum Allowance (after deductible)
▪ Well-Woman Care (including routine GYN exam and Pap smear)	None (does not apply to HSA)	100% of Negotiated Fees (no deductible)	$9,000/$13,500/$18,000	50% of Maximum Allowance (after deductible)

Type of Service	Core HSA			
	Network*		Out-of-Network (Maximum Allowance Limits Apply)*	
	You Pay (Annual Deductible)	Plan Pays (Coinsurance)**	You Pay (Annual Deductible)	Plan Pays (Coinsurance)**
▪ Routine Mammograms	None (does not apply to HSA)	100% of Negotiated Fees (no deductible)	$9,000/$13,500/$18,000	50% of Maximum Allowance (after deductible)
▪ Well-Man Care (prostate-specific antigen [PSA]/digital rectal exam [DRE])	None (does not apply to HSA)	100% of Negotiated Fees (no deductible)	$9,000/$13,500/$18,000	50% of Maximum Allowance (after deductible)
▪ Eye Exams (routine only) Vision eyewear benefit is through Blue Cross Blue Shield Vision Discount Program	None (does not apply to HSA)	100% of Negotiated Fees (no deductible)	$9,000/$13,500/$18,000	50% of Maximum Allowance (after deductible)
▪ Hearing Exams (routine only)	None (does not apply to HSA)	100% of Negotiated Fees (no deductible)	$9,000/$13,500/$18,000	50% of Maximum Allowance (after deductible)
▪ Routine Wellness Screenings	None (does not apply to HSA)	100% of Negotiated Fees (no deductible)	$9,000/$13,500/$18,000	50% of Maximum Allowance (after deductible)
Other Covered Services				
▪ Acupuncture in Lieu of Anesthesia Only	$4,500/$6,750/$9,000	70% of Negotiated Fees (after deductible)	$9,000/$13,500/$18,000	50% of Maximum Allowance (after deductible)
▪ Allergy Treatments/ Injections (received outside of office visit or not received by a physician)	$4,500/$6,750/$9,000	70% of Negotiated Fees (after deductible) (unless office visit charge is waived)	$9,000/$13,500/$18,000	50% of Maximum Allowance (after deductible)
▪ Anesthetics	$4,500/$6,750/$9,000	70% of Negotiated Fees (after deductible)	$9,000/$13,500/$18,000	50% of Maximum Allowance (after deductible)

Type of Service	Core HSA			
	Network*		Out-of-Network (Maximum Allowance Limits Apply)*	
	You Pay (Annual Deductible)	Plan Pays (Coinsurance)**	You Pay (Annual Deductible)	Plan Pays (Coinsurance)**
▪ Bariatric Surgery (through Blue Distinction Centers only; **preauthorization required; see "The Managed Care Program" main section**)	$4,500/$6,750/$9,000	80% of Negotiated Fees (after deductible) Benefits also may be payable for travel and lodging expenses.	Not Covered	Not Covered
▪ Dental Services (medical in nature only, impacted teeth not covered)	$4,500/$6,750/$9,000	70% of Negotiated Fees (after deductible)	$9,000/$13,500/$18,000	50% of Maximum Allowance (after deductible)
▪ Drugs and Medications (prescribed during an inpatient stay)	$4,500/$6,750/$9,000	70% of Negotiated Fees (after deductible)	$9,000/$13,500/$18,000	50% of Maximum Allowance (after deductible)
▪ Durable Medical and Surgical Equipment/ Prosthetics	$4,500/$6,750/$9,000	70% of Negotiated Fees (after deductible)	$9,000/$13,500/$18,000	50% of Maximum Allowance (after deductible)
▪ Hearing Aids for Children with Congenital Defects, Up to Age 19	$4,500/$6,750/$9,000	70% of Negotiated Fees (after deductible)	$9,000/$13,500/$18,000	50% of Maximum Allowance (after deductible)
▪ Mastectomy Services	$4,500/$6,750/$9,000	70% of Negotiated Fees (after deductible)	$9,000/$13,500/$18,000	50% of Maximum Allowance (after deductible)
▪ Transplant Services (coordination by patient with transplant coordinator; Blue Distinction Center is required)	$4,500/$6,750/$9,000	100% of Negotiated Fees (after deductible) at Blue Distinction Center	Not Covered	Not Covered
▪ Diabetic foot orthotics	$4,500/$6,750/$9,000	70% of Negotiated Fees (after deductible)	$9,000/$13,500/$18,000	50% of Maximum Allowance (after deductible)

Type of Service	Core HSA			
	Network*		Out-of-Network (Maximum Allowance Limits Apply)*	
	You Pay (Annual Deductible)	Plan Pays (Coinsurance)**	You Pay (Annual Deductible)	Plan Pays (Coinsurance)**
Behavioral Health and Substance Abuse Treatments (preauthorization required; see "The Managed Care Program" main section)				
▪ Inpatient (including a residential treatment facility)	$4,500/$6,750/$9,000	70% of Negotiated Fees (after deductible)	$9,000/$13,500/$18,000	50% of Maximum Allowance (after deductible)
▪ Outpatient (including partial hospitalization)	$4,500/$6,750/$9,000	70% of Negotiated Fees (after deductible)	$9,000/$13,500/$18,000	50% of Maximum Allowance (after deductible)

The Plan considers your expense incurred on the day you receive the service or supply. It doesn't pay benefits for any expense you incur before coverage begins or after coverage ends (even if the expense is due to an *accident*, *injury*, or *illness* that occurs while your coverage is in effect).

A Snapshot of Your Blue Cross Blue Shield PPO Plan Coverage

Deductibles, Copays, Coinsurance, Out-of-Pocket Maximums, and Maximum Benefits

Here is a snapshot of the annual *deductibles*, *copays*, *coinsurance*, annual out-of-pocket maximums, and maximum benefits that apply under the Blue Cross Blue Shield PPO Plan coverage option. Many of these terms are defined under the "How Your Coverage Works" main section.

	Blue Cross Blue Shield PPO Plan	
Feature	**Network**	**Out-of-Network (Maximum Allowance Limits Apply)***
	You Pay	**You Pay**
Annual Deductible (Includes network/out-of-network providers)		
▪ Individual	$600	$1,200
▪ Family	$1,200	$2,400
Copays		
▪ Office Visit Copays (Applicable Copay Applies Based on Provider of the Care/Treatment Received)	$20 PCP/ $35 Specialist	None
Annual Out-of-Pocket Maximum (includes network/out-of-network providers; includes deductible and copays; excludes prescription drug expenses)		
▪ Individual	$2,500	$5,000
▪ Family	$5,000	$10,000

* The Plan pays benefits for *Eligible Expenses.* For *out-of-network care*, *eligible expenses* are based on *maximum allowance*. You're responsible for any charge that exceeds the *maximum allowance*.

	Blue Cross Blue Shield PPO Plan	
Feature	**Network**	**Out-of-Network (Maximum Allowance Limits Apply)***
	You Pay	**You Pay**
Annual Prescription Drug Expense Out-of-Pocket Maximum		
▪ Individual	$2,100	100%; no coverage out-of-network
▪ Family	$4,200	100%; no coverage out-of-network
	Plan Pays	**Plan Pays**
Coinsurance	Generally, 80% of Negotiated Fees for Eligible Expenses (after deductible)	Generally, 60% of Maximum Allowance for Eligible Expenses (after deductible)
▪ Blue Distinction Centers required for transplants and bariatric; optional for knee/hip replacement, spine, cardiac care, and rare cancers, but provides a higher level of benefit	Generally, 90% of Negotiated Fees for Eligible Expenses Benefits also may be payable for travel and lodging expenses.	No coverage out-of-network
Lifetime Maximum Benefit	No Limit	
Feature	**Plan Pays Benefits For ...**	
▪ Coordinated Home Health or Skilled Nursing Care	Up to 120 Visits Per Calendar Year (applies to all combined covered network and out-of-network services)	
▪ Private Duty Nursing Care	Up to 70 Days Per Calendar Year	
▪ Outpatient Short-Term Rehabilitation (physical, occupational, and speech therapy)	Up to 60 Combined Visits Per Calendar Year (applies to all combined covered network and out-of-network services; limitations may apply)	
▪ Spinal Disorders (spinal manipulations performed by an M.D., D.O., chiropractor, or therapist)	Up to 60 Visits Per Calendar Year (applies to all combined covered network and out-of-network services; limitations may apply; care subject to review at 20 visits)	

* The Plan pays benefits for *Eligible Expenses.* For *out-of-network care*, *eligible expenses* are based on *maximum allowance*. You're responsible for any charge that exceeds the *maximum allowance*.

	Blue Cross Blue Shield PPO Plan	
Feature	**Network**	**Out-of-Network (Maximum Allowance Limits Apply)***
	Plan Pays Benefits For ...	
▪ Family Planning	Limited to the Diagnosis and Treatment of the Underlying Cause of Infertility Only	
▪ Transplant Services (coordination by patient with transplant coordinator; Blue Distinction Center is required)	Requires preauthorization and use of **claims administrator-approved human organ transplant programs** to receive benefits. Benefits also are payable for travel and lodging expenses.	
▪ Well-Child Care (includes routine immunizations, travel immunizations, and flu shots)	No limit for routine care	60% of Maximum Allowance for Eligible Expenses (after deductible)
▪ Adult Routine Physical Exams (includes routine immunizations and flu shots)	No limit for routine care	60% of Maximum Allowance for Eligible Expenses (after deductible)
▪ Well-Woman Care	No limit for routine care	60% of Maximum Allowance for Eligible Expenses (after deductible)
▪ Routine Mammograms	No limit for routine care	60% of Maximum Allowance for Eligible Expenses (after deductible)
▪ Well-Man Care (prostate-specific antigen [PSA]/digital rectal exam [DRE])	No limit for routine care	60% of Maximum Allowance for Eligible Expenses (after deductible)
▪ Colorectal Cancer Screenings	No limit for routine care	60% of Maximum Allowance for Eligible Expenses (after deductible)
▪ Routine Eye Exams	One Exam Every 24 Months	
▪ Routine Hearing Exams	One Exam Every 24 Months	
▪ Hearing Aids for Congenital Defects Only	**Covered to Age 19:** Hearing aids are subject to deductible and coinsurance (limited to one per ear per year).	

Types of Covered Services

Here is a snapshot of the types of services the Plan covers under this option. The services listed are further detailed under the "What the Plan Covers" main section. You're also eligible for prescription drug coverage. See "The CVS Caremark Prescription Drug Program for the Blue Cross Blue Shield National Coverage Options" main section for details.

The benefits outlined below are generally covered as shown, but cost-sharing is based upon the type and place of treatment as well as facility billing practices.

Type of Service	Blue Cross Blue Shield PPO Plan				
	Network*			Out-of-Network (Maximum Allowance Limits Apply)*	
	You Pay (Annual Deductible)	You Pay (Copay)+	Plan Pays (Coinsurance)**	You Pay (Annual Deductible)	Plan Pays (Coinsurance)**
Inpatient Services (preauthorization required; see "The Managed Care Program" main section)					
▪ Room and Board and Miscellaneous Hospital Expenses	$600/$1,200	None	80% of Negotiated Fees (after deductible)	$1,200/$2,400	60% of Maximum Allowance (after deductible)
▪ Physician Services While Hospitalized	$600/$1,200	None	80% of Negotiated Fees (after deductible)	$1,200/$2,400	60% of Maximum Allowance (after deductible)
▪ Routine Nursery Care	$600/$1,200	None	80% of Negotiated Fees (after deductible)	$1,200/$2,400	60% of Maximum Allowance (after deductible)
▪ Prescription Drugs While Hospitalized and Other Inpatient Care	$600/$1,200	None	80% of Negotiated Fees (after deductible)	$1,200/$2,400	60% of Maximum Allowance (after deductible)

* When paying benefits, the Plan considers whether or not a service is medically necessary. It also considers the *negotiated fee* (applies for *network care*), whether the charge is the *maximum allowance* (applies for *out-of-network care*), and whether you have coverage from other sources. See the "Coordination of Benefits (COB)" main section for details. You're responsible for any charge that exceeds the *maximum allowance* amount when you receive *out-of-network care,* unless you receive emergency *ambulance service* or care from a radiologist, anesthesiologist or pathologist while hospitalized and you have no choice in *provider*. Contact the *claims administrator* for more information.

+ Applicable *copay* applies based on provider of the care/treatment received.

** All percentages shown are percentages of either the *negotiated fee* or *maximum allowance* charge for the *eligible expense*.

Type of Service	Blue Cross Blue Shield PPO Plan				
	Network*			Out-of-Network (Maximum Allowance Limits Apply)*	
	You Pay (Annual Deductible)	You Pay (Copay)+	Plan Pays (Coinsurance)**	You Pay (Annual Deductible)	Plan Pays (Coinsurance)**
Alternatives to Inpatient Hospital Care (preauthorization required; see "The Managed Care Program" main section)					
▪ Coordinated Home Health or Skilled Nursing Care	$600/$1,200	None	80% of Negotiated Fees (after deductible)	$1,200/$2,400	60% of Maximum Allowance (after deductible)
▪ Private Duty Nursing Care	$600/$1,200	None	80% of Negotiated Fees (after deductible)	$1,200/$2,400	60% of Maximum Allowance (after deductible)
▪ Hospice Care	$600/$1,200	None	80% of Negotiated Fees (after deductible)	$1,200/$2,400	60% of Maximum Allowance (after deductible)
Outpatient Services (preauthorization required; see "The Managed Care Program" main section)					
▪ Hospital Facility Expenses	$600/$1,200	None	80% of Negotiated Fees (after deductible)	$1,200/$2,400	60% of Maximum Allowance (after deductible)
▪ Hospice Care	$600/$1,200	None	80% of Negotiated Fees (after deductible)	$1,200/$2,400	60% of Maximum Allowance (after deductible)
Surgical Expenses (preauthorization required; see "The Managed Care Program" main section)					
▪ Inpatient Surgical Expenses	$600/$1,200	None	80% of Negotiated Fees (after deductible)	$1,200/$2,400	60% of Maximum Allowance (after deductible)
▪ Outpatient Surgical Expenses (surgeon's charges excluding surgical office visits)	$600/$1,200	None	80% of Negotiated Fees (after deductible)	$1,200/$2,400	60% of Maximum Allowance (after deductible)

* When paying benefits, the Plan considers whether or not a service is medically necessary. It also considers the *negotiated fee* (applies for *network care*), whether the charge is the *maximum allowance* (applies for *out-of-network care*), and whether you have coverage from other sources. See the "Coordination of Benefits (COB)" main section for details. You're responsible for any charge that exceeds the *maximum allowance* amount when you receive *out-of-network care,* unless you receive emergency *ambulance service* or care from a radiologist, anesthesiologist or pathologist while hospitalized and you have no choice in *provider*. Contact the *claims administrator* for more information.

+ Applicable *copay* applies based on provider of the care/treatment received.

** All percentages shown are percentages of either the *negotiated fee* or *maximum allowance* charge for the *eligible expense*.

Type of Service	Blue Cross Blue Shield PPO Plan				
	Network*			Out-of-Network (Maximum Allowance Limits Apply)*	
	You Pay (Annual Deductible)	You Pay (Copay)+	Plan Pays (Coinsurance)**	You Pay (Annual Deductible)	Plan Pays (Coinsurance)**
▪ Oral Surgical Procedures (when medical in nature only; impacted teeth not covered)	$600/$1,200	None	80% of Negotiated Fees (after deductible)	$1,200/$2,400	60% of Maximum Allowance (after deductible)
▪ Second Surgical Opinions	$600/$1,200	None	80% of Negotiated Fees (after deductible)	$1,200/$2,400	60% of Maximum Allowance (after deductible)
▪ Preoperative Testing	$600/$1,200	None	80% of Negotiated Fees (after deductible)	$1,200/$2,400	60% of Maximum Allowance (after deductible)
Emergency Medical Care Services					
▪ Professional Services (office visit)	None	Per-Office-Visit Copay Applies: $20 PCP/ $35 Specialist	80% of Negotiated Fees (after deductible)	$1,200/$2,400	80% of Maximum Allowance (after deductible)
▪ Hospital Emergency Room (not followed by admission)	$600/$1,200	None	80% of Negotiated Fees (after deductible) If a True Emergency Non-Emergency Use Not Covered	$1,200/$2,400	80% of Maximum Allowance (after deductible) If a True Emergency Non-Emergency Use Not Covered
▪ Urgent Care Facility	None	None	80% of Negotiated Fees Non-Emergency Use Not Covered	$1,200/$2,400	60% of Maximum Allowance (after deductible) If a True Emergency Non-Emergency Use Not Covered

Type of Service	Blue Cross Blue Shield PPO Plan				
	Network*			Out-of-Network (Maximum Allowance Limits Apply)*	
	You Pay (Annual Deductible)	You Pay (Copay)+	Plan Pays (Coinsurance)**	You Pay (Annual Deductible)	Plan Pays (Coinsurance)**
▪ Ambulance Services	$600/$1,200	None	80% of Negotiated Fees (after deductible) If a True Emergency Non-Emergency Use Not Covered	$1,200/$2,400	80% of Maximum Allowance (after deductible) If a True Emergency Non-Emergency Use Not Covered
Professional Services					
▪ Physician Office Visits	None	$20 Per Office Visit	100% of Negotiated Fees (after copay)	$1,200/$2,400	60% of Maximum Allowance (after deductible)
▪ Specialist Office Visits/Consultations	None	$35 Per Office Visit	100% of Negotiated Fees (after copay)	$1,200/$2,400	60% of Maximum Allowance (after deductible)
▪ MDLive Telehealth Virtual Visit	None	$20 Per Visit	NA	N/A	NA
▪ Office Visit Associated with Allergy Testing	None	$35 Per Office Visit	100% of Negotiated Fees (after copay)	$1,200/$2,400	60% of Maximum Allowance (after deductible)
Diagnostic Procedures					
▪ Services Performed by a Radiologist, Anesthesiologist, or Pathologist	$600/$1,200	None	80% of Negotiated Fees (after deductible)	$1,200/$2,400	60% of Maximum Allowance (after deductible)

* When paying benefits, the Plan considers whether or not a service is medically necessary. It also considers the *negotiated fee* (applies for *network care*), whether the charge is the *maximum allowance* (applies for *out-of-network care*), and whether you have coverage from other sources. See the "Coordination of Benefits (COB)" main section for details. You're responsible for any charge that exceeds the *maximum allowance* amount when you receive *out-of-network care,* unless you receive emergency *ambulance service* or care from a radiologist, anesthesiologist or pathologist while hospitalized and you have no choice in *provider*. Contact the *claims administrator* for more information.

+ Applicable *copay* applies based on provider of the care/treatment received.

** All percentages shown are percentages of either the *negotiated fee* or *maximum allowance* charge for the *eligible expense*.

Type of Service	Blue Cross Blue Shield PPO Plan				
	Network*			Out-of-Network (Maximum Allowance Limits Apply)*	
	You Pay (Annual Deductible)	You Pay (Copay)+	Plan Pays (Coinsurance)**	You Pay (Annual Deductible)	Plan Pays (Coinsurance)**
▪ Diagnostic X-Ray and Lab Tests (performed as part of an office visit and billed by a physician)	None	Per-Office-Visit Copay Applies: $20 PCP/ $35 Specialist	100% of Negotiated Fees (after copay)	$1,200/$2,400	60% of Maximum Allowance (after deductible)
▪ Outpatient Diagnostic X-Ray and Lab Tests (performed in an outpatient hospital or other outpatient facility/setting/independent lab and billed by a lab or clinic)	$600/$1,200	None	80% of Negotiated Fees (after deductible)	$1,200/$2,400	60% of Maximum Allowance (after deductible)
▪ Complex Imaging Services (e.g. MRA/MRS, MRI, CT scans, PET scans; **preauthorization required, see "The Managed Care Program" main section**)	$600/$1,200	None	80% of Negotiated Fees (after deductible)	$1,200/$2,400	60% of Maximum Allowance (after deductible)
Outpatient Therapy					
▪ Short-Term Rehabilitation Physician's Services	None	$35 Per Office Visit	100% of Negotiated Fees (after copay)	$1,200/$2,400	60% of Maximum Allowance (after deductible)
▪ Short-Term Rehabilitation Services of a Physical, Speech, or Occupational Therapist	$600/$1,200 If Not Billed as an Office Visit	$35 Per Office Visit; Unless Billed by a Facility Where Deductible/ Coinsurance Apply	100% of Negotiated Fees (after copay)	$1,200/$2,400	60% of Maximum Allowance (after deductible)

Type of Service	Blue Cross Blue Shield PPO Plan				
	Network*			Out-of-Network (Maximum Allowance Limits Apply)*	
	You Pay (Annual Deductible)	You Pay (Copay)+	Plan Pays (Coinsurance)**	You Pay (Annual Deductible)	Plan Pays (Coinsurance)**
▪ Treatment of Spinal Disorders	$600/$1,200 If Not Billed as an Office Visit	$35 Per Office Visit; Unless Billed by a Facility Where Deductible/ Coinsurance Apply	100% of Negotiated Fees (after copay)	$1,200/$2,400	60% of Maximum Allowance (after deductible)
▪ Infusion Therapy Performed in the Home, Office, or Outpatient Facility	$600/$1,200	None	80% of Negotiated Fees (after deductible)	$1,200/$2,400	60% of Maximum Allowance (after deductible)
▪ Cardiac/Pulmonary Rehabilitation Therapy	$600/$1,200	None	80% of Negotiated Fees (after deductible)	$1,200/$2,400	60% of Maximum Allowance (after deductible)
Maternity—Prenatal and Postnatal Care (preauthorization required; see "The Managed Care Program" main section)					
▪ Initial Visit to Confirm Pregnancy	None	$20 for Initial Office Visit	100% of Negotiated Fees (after copay)	$1,200/$2,400	60% of Maximum Allowance (after deductible)
▪ All Subsequent Prenatal and Postnatal Visits	$600/$1,200	None	80% of Negotiated Fees (after deductible)	$1,200/$2,400	60% of Maximum Allowance (after deductible)
▪ Delivery Charges (including inpatient hospital routine nursery care)	$600/$1,200	None	80% of Negotiated Fees (after deductible)	$1,200/$2,400	60% of Maximum Allowance (after deductible)
▪ Free-Standing Birthing Centers	$600/$1,200	None	80% of Negotiated Fees (after deductible)	$1,200/$2,400	60% of Maximum Allowance (after deductible)

Type of Service	Blue Cross Blue Shield PPO Plan				
	Network*			Out-of-Network (Maximum Allowance Limits Apply)*	
	You Pay (Annual Deductible)	You Pay (Copay)+	Plan Pays (Coinsurance)**	You Pay (Annual Deductible)	Plan Pays (Coinsurance)**
Family Planning					
▪ Infertility Treatments (the diagnosis and treatment of the underlying cause of infertility only)	$600/$1,200	None	80% of Negotiated Fees (after deductible)	$1,200/$2,400	60% of Maximum Allowance (after deductible)
▪ Office Visit Associated with Contraceptives, Implants, Devices, and Injectables	None	$20 Per Office Visit	100% of Negotiated Fees (after copay)	$1,200/$2,400	60% of Maximum Allowance (after deductible)
▪ Voluntary Abortions	$600/$1,200	None	80% of Negotiated Fees (after deductible)	$1,200/$2,400	60% of Maximum Allowance (after deductible)
▪ Voluntary Sterilization	$600/$1,200	None	80% of Negotiated Fees (after deductible)	$1,200/$2,400	60% of Maximum Allowance (after deductible)
Preventive Care (age and frequency limits apply). Must be billed as preventive.					
▪ Well-Child Care (including routine immunizations and flu shots)	None	None	100% of Negotiated Fees	$1,200/$2,400	60% of Maximum Allowance (after deductible)
▪ Adult Routine Physical Exams (including routine immunizations and flu shots)	None	None	100% of Negotiated Fees	$1,200/$2,400	60% of Maximum Allowance (after deductible)
▪ Well-Woman Care (including routine GYN exam and Pap smear)	None	None	100% of Negotiated Fees	$1,200/$2,400	60% of Maximum Allowance (after deductible)
▪ Routine Mammograms	None	None	100% of Negotiated Fees	$1,200/$2,400	60% of Maximum Allowance (after deductible)

Type of Service	Blue Cross Blue Shield PPO Plan				
	Network*			Out-of-Network (Maximum Allowance Limits Apply)*	
	You Pay (Annual Deductible)	You Pay (Copay)+	Plan Pays (Coinsurance)**	You Pay (Annual Deductible)	Plan Pays (Coinsurance)**
▪ Well-Man Care (prostate-specific antigen [PSA]/digital rectal exam [DRE])	None	None	100% of Negotiated Fees	$1,200/$2,400	60% of Maximum Allowance (after deductible)
▪ Eye Exams (routine only) Blue Cross Blue Shield Offers a Vision Discount Program	None	None	100% of Negotiated Fees	$1,200/$2,400	60% of Maximum Allowance (after deductible)
▪ Hearing Exams (routine only)	None	None	100% of Negotiated Fees	$1,200/$2,400	60% of Maximum Allowance (after deductible)
▪ Routine Wellness Screenings	None	None	100% of Negotiated Fees	$1,200/$2,400	60% of Maximum Allowance (after deductible)
Other Covered Services					
▪ Acupuncture in Lieu of Anesthesia Only	$600/$1,200	None	80% of Negotiated Fees (after deductible)	$1,200/$2,400	60% of Maximum Allowance (after deductible)
▪ Allergy Treatments/Injections	None	$35 Per Office Visit (waived if no office visit charge is made)	100% of Negotiated Fees (after copay)	$1,200/$2,400	60% of Maximum Allowance (after deductible)
▪ Anesthetics	$600/$1,200	None	80% of Negotiated Fees (after deductible)	$1,200/$2,400	60% of Maximum Allowance (after deductible)

Type of Service	Blue Cross Blue Shield PPO Plan				
	Network*			Out-of-Network (Maximum Allowance Limits Apply)*	
	You Pay (Annual Deductible)	You Pay (Copay)+	Plan Pays (Coinsurance)**	You Pay (Annual Deductible)	Plan Pays (Coinsurance)**
▪ Bariatric Surgery (through Blue Distinction Centers only; **preauthorization required; see "The Managed Care Program" main section**)	None	None	90% of Negotiated Fees Benefits also may be payable for travel and lodging expenses.	Not Covered	Not Covered
▪ Dental Services (medical in nature only, impacted teeth not covered)	$600/$1,200	None	80% of Negotiated Fees (after deductible)	$1,200/$2,400	60% of Maximum Allowance (after deductible)
▪ Drugs and Medications (prescribed during an inpatient stay)	$600/$1,200	None	80% of Negotiated Fees (after deductible)	$1,200/$2,400	60% of Maximum Allowance (after deductible)
▪ Durable Medical and Surgical Equipment/ Prosthetics	$600/$1,200	None	80% of Negotiated Fees (after deductible)	$1,200/$2,400	60% of Maximum Allowance (after deductible)
▪ Hearing Aids for Children with Congenital Defects, Up to Age 19	$600/$1,200	None	80% of Negotiated Fees (after deductible)	$1,200/$2,400	60% of Maximum Allowance (after deductible)
▪ Mastectomy Services	$600/$1,200	None	80% of Negotiated Fees (after deductible)	$1,200/$2,400	60% of Maximum Allowance (after deductible)

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+ Applicable *copay* applies based on provider of the care/treatment received.

** All percentages shown are percentages of either the *negotiated fee* or *maximum allowance* charge for the *eligible expense*.

Type of Service	Blue Cross Blue Shield PPO Plan				
	Network*			Out-of-Network (Maximum Allowance Limits Apply)*	
	You Pay (Annual Deductible)	You Pay (Copay)+	Plan Pays (Coinsurance)**	You Pay (Annual Deductible)	Plan Pays (Coinsurance)**
▪ Transplant Services (coordination by patient with transplant coordinator; Blue Distinction Center is required)	None	None	90% of Negotiated Fees	Not Covered	Not Covered
▪ Diabetic Foot Orthotics	$600/$1,200	None	80% of Negotiated Fees (after deductible)	$1,200/$2,400	60% of Maximum Allowance (after deductible)
Behavioral Health and Substance Abuse Treatments (preauthorization required; see "The Managed Care Program" main section)					
▪ Inpatient (including a residential treatment facility)	$600/$1,200	None	80% of Negotiated Fees (after deductible)	$1,200/$2,400	60% of Maximum Allowance (after deductible)
▪ Outpatient (e.g., including partial hospitalization)	$600/$1,200; If Billed as an Office Visit, None	None; Unless Billed as an Office Visit Then Copay Applies	80% of Negotiated Fees (after deductible)	$1,200/$2,400	60% of Maximum Allowance (after deductible)

The Plan considers your expense incurred on the day you receive the service or supply. It doesn't pay benefits for any expense you incur before coverage begins or after coverage ends (even if the expense is due to an *accident*, *injury*, or *illness* that occurs while your coverage is in effect).

The Health Maintenance Organizations (HMOs)

About HMOs

WKUS offers HMO coverage options in some areas. The HMO available to you depends on where you live. Your enrollment information includes the HMO coverage options for which you're eligible.

Remember, this SPD doesn't describe HMO coverage in detail. If you're an HMO participant, please refer to the medical coverage details page on the Your Benefits Resources website. You also can obtain detailed information that describes your HMO coverage directly from your HMO.

Eligibility

Overview

Not all employees are eligible to participate in the Plan. As long as you meet the eligibility requirements, you can participate in the Plan. Your dependents also may be eligible for coverage. Here are more details about the Plan's eligibility requirements.

Employees

You're eligible for coverage under the Plan if you meet the following requirements:

- You're a regular *Full-time Employee* of the *Company* working at least 30 hours per week (you're eligible to participate on your first day of *active work*); or
- You're a regular *Part-time Employee* of the *Company* working or scheduled to work at least 20 hours per week, you've completed one *year of service*, and you're *actively at work*.

Please also see the “Administrative Information” main section for a list of subsidiaries that participate in and have adopted this Plan.

If you're hired by the *Company* as a temporary, contract, seasonal, leased, or on-call employee (regardless of the number of hours per year you're scheduled to work), you're not eligible to participate in the Plan because you don't meet the definition of a *Full-* or *Part-time Employee*. Additionally, if you're classified by the *Company* as an independent contractor, you're not eligible to participate.

If You Become Ineligible

You may remain an employee of the *Company* but become ineligible for coverage because you no longer meet the definition of a regular *Full-* or *Part-time Employee*. If this is the case, you immediately become eligible for coverage on the day you again become a regular *Full-* or *Part-time Employee*.

In addition, coverage is sometimes continued even if you don't meet the eligibility requirements described above, such as in certain cases involving a disability. Please see “Instances When Coverage May Continue” in the “How Long Coverage Continues” main section for more information.

If You're Rehired

If you terminate employment and subsequently return to work as a *Full-time Employee*, you're eligible to participate in the Plan as of your first day of *active work*.

If you're rehired as a *Part-time Employee* within 12 months of the day you terminate employment and you were eligible prior to your termination, you're eligible to participate in the Plan on your first day of *active work*. If you're rehired as a *Part-time Employee* more than 12 months after the day you terminate employment, or if you were not eligible prior to your termination, you're eligible to participate in the Plan on your first day of *active work* after you complete one *year of service*.

If you're a retiree and you're rehired by the *Company* on a permanent basis, you and your eligible dependents are eligible to participate in the Plan (the coverage options available for an active employee) on your first day of *active work*, regardless of whether you're rehired on a regular *Full-time* or *Part-time Employee* basis.

Your Dependents

Your dependents may be eligible for coverage under the Plan. Your eligible dependents include your:

- Legal spouse. Coverage for a spouse is limited to the eligible employee's legal partner in marriage as defined by the Federal Defense of Marriage Act (“DOMA”), and from whom the eligible employee isn't legally divorced.

  Please notify Your Benefits Resources within 31 days of the day you become legally divorced or separated, or your spouse ceases to meet the definition of an eligible dependent.
- Same- or opposite-sex *domestic partner*, provided he or she meets the eligibility requirements of the coverage option you select. Same- or opposite-sex *domestic partners* are eligible for coverage under the self-insured coverage options; however, eligibility requirements **may** vary for the HMO coverage options.

  You'll be required to contact the Your Benefits Resources Customer Service Center to validate eligibility before coverage begins.
- Unmarried or married child, including:
  - Your natural children;
  - Your stepchildren;
  - Your foster children;
  - Your legally adopted children or children placed with you for adoption;
  - Any other children for whom you provide child support as a result of a court order; and
  - Any child of your *domestic partner* who meets any of the above criteria.

  Please note: Your child must also meet the age and/or disability requirements described below. Also, if your child is eligible for coverage under the Plan, his or her child is not eligible for coverage under the Plan nor is your child's spouse eligible for coverage under the Plan.

- Child required to be covered pursuant to the terms of a *Qualified Medical Child Support Order (QMCSO).* This coverage may apply even if you don't have legal custody of the child, the child isn't dependent on you for support, and regardless of any enrollment season restrictions that might otherwise exist for dependent coverage. See “Enrollment Pursuant to a QMCSO” under the “How to Enroll” main section for more information. However, a child is eligible for this coverage only to the extent required by the *QMCSO* and the coverage will automatically end when the *QMCSO* no longer requires the provision of coverage unless the child is eligible (and you affirmatively elect) continued coverage as described below.

Coverage for your child continues (as long as your own coverage continues) until the end of the month in which he or she turns age 26. Different age limits may apply for certain HMO coverages. Be sure to review your separate HMO materials or contact your HMO directly for details.

Please notify Your Benefits Resources within 31 days of the day your dependent ceases to meet the definition of an eligible dependent. Coverage is available beyond age 26 for *mentally or physically disabled* dependents, if the disability commenced prior to their attainment of age 19. See “Eligibility Requirements for Mentally or Physically Disabled Dependents” under this subsection for details.

Parents, grandparents, grandchildren, nieces/nephews, adult siblings, or any person in the armed forces of any country aren't considered to be eligible dependents.

It's important to confirm that the dependents you claim under the Plan (including each coverage option) meet the definition to be eligible under the Wolters Kluwer Plan (or Plan coverage option). For each dependent you elect to enroll in a Wolters Kluwer Plan, you'll be required to provide certain documentation to verify that your dependent meets the Wolters Kluwer eligibility guidelines. Your dependent(s) will be added to coverage upon enrollment, however if documentation is not approved by the deadline, they will be dropped from coverage prospectively The *Company* further reserves the right to audit the eligibility of all dependents covered under the Plan. If any dependent is found to be ineligible during the audit, he or she will be dropped from coverage. Covering an ineligible dependent is most likely considered fraud. If fraud is discovered, Wolters Kluwer will review the situation and will take appropriate employee disciplinary action.

Eligibility Requirements for Mentally or Physically Disabled Dependents

If your dependent child is *mentally or physically disabled* (as defined by the Plan) and he or she is covered and considered disabled under the Plan on his or her 19th birthday, he or she may qualify for continuation of coverage beyond age 26 (provided the disability continues, the dependent continues to be incapable of earning a living, and you remain an eligible covered employee).

If you have a disabled child, please contact Your Benefits Resources before your child's 26th birthday so that coverage can be verified by the medical *claims administrator* and continued after reaching age 26. You may have a disabled child at the point you enroll in the *Company's* benefit plan *(following your* date of hire, acquisition, or qualifying life event). If your disabled child meets the eligibility requirements as stated above, and the *claims administrator* certifies that he or she is disabled, your child may be considered an eligible dependent. Contact Your Benefits Resources upon receipt of this notification so your dependent’s eligibility can be updated. If your child is considered an eligible dependent, he or she is eligible for coverage.

Coverage for a *mentally or physically disabled* dependent child ends on the day he or she is no longer disabled/incapacitated, he or she fails to submit to a required medical exam, or you fail to submit any required proof of your dependent's disability/incapacity.

Medicare-Eligible Covered Persons

A series of federal laws collectively referred to as the ‘‘*Medicare Secondary Payer*’’ (*MSP*) laws regulate the manner in which certain employers may offer group health care coverage to *Medicare*-eligible employees, spouses, and in some cases, dependent children.

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

- With respect to individuals with end-stage renal disease (“ESRD”) during the first 30 months of Medicare eligibility or entitlement. This is the case regardless of whether the individual has “current employment status.”
- In the case of individuals age 65 or over, if that individual or the individual’s spouse (of any age) has “regular full-time or part-time employment status.”
- In the case of disabled individuals under age 65, if the individual or a member of the individual’s family has “regular full-time or part-time employee status.”

More information about coverage for *Medicare*-eligible employees and dependents is provided below in “How Coordination Works With Medicare,” found in the “Coordination of Benefits (COB)” main section. See also ‘‘Benefits for Medicare-Eligible Covered Persons,’’ found in the “What the Plan Covers” main section.

Your MSP Responsibility

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

Dependent Coverage Under the WKUS Retiree Health Plan

In certain instances, you and/or your dependents may no longer meet the eligibility requirements for medical coverage under the WKUS Health Plan but may be eligible for medical coverage under the WKUS Retiree Health Plan. A brief summary of the eligibility rules for dependents under the WKUS Retiree Health Plan is set forth below, but you should refer to the SPD for the WKUS Retiree Health Plan for detailed eligibility rules for retirees and dependents under that plan.

- **If You Die While Actively Employed:** Your dependents are eligible for medical coverage under the WKUS Retiree Health Plan if you meet the eligibility requirements of the grandfathered Retiree Medical Plan or the Retiree Medical Savings Account (RMSA) as of your date of death:
    - **Grandfathered Retiree Medical Plan:** You were a benefit-eligible employee of Wolters Kluwer, and were at least age 50, on July 1, 2007 (with no subsequent dates of termination); and, you die when age 55 or older with at least 10 years of service (as defined under the WKUS Retiree Health Plan) with the *Company* on the date of your death; or

- **RMSA:** You were a benefit-eligible employee of Wolters Kluwer, and were age 49 or younger, on July 1, 2007, or newly eligible (including rehires) for benefits with Wolters Kluwer after this date; and, you die when age 60 or older with at least 10 years of service (as defined under the WKUS Retiree Health Plan) with the *Company* on the date of your death;
- You die while you're still employed by the *Company*; and
- Your eligible dependents are covered under the WKUS Health Plan at the time of your death.

Please see the SPD for the WKUS Retiree Health Plan for more details.

- **If You're Eligible for Long-Term Disability Benefits:** You and your dependents are eligible for medical coverage under the WKUS Retiree Health Plan if you meet the eligibility rules outlined above when you transition to Long-Term Disability Plan benefits (regardless of whether you elected coverage under the WKUS Long-Term Disability Plan).

  Please see the SPD for the WKUS Retiree Health Plan for more details.

How to Enroll

Overview

When you're first eligible, and each year during Annual Enrollment, you have the opportunity to select the coverage option you want for yourself and your eligible dependents under the group health plans (the WKUS Health Plan). This section highlights the enrollment process.

Enrolling in the Plan

You can enroll online or by phone. Enrollment information may include:

- Important tips on how to enroll upon your date of hire (initial enrollment) or for the upcoming *Plan Year*;
- Enrollment procedures, including how to enroll online or by phone;
- Detailed information regarding the coverage options for which you're eligible for the upcoming *Plan Year*;
- Additional online tools to help you decide which coverage option is most appropriate for you;
- Your cost for each coverage option; and
- Any changes that may have taken place since the last Annual Enrollment period.

Enrolling Online

When you're first eligible and during each Annual Enrollment, you may enroll for coverage online via the Your Benefits Resources website. This site provides complete, personalized information about your specific coverage options and related premium costs. Here are a few helpful hints if you decide to enroll online.

- **Review Information:** Be sure to review the detailed information available on Your Benefits Resources (if you have Internet access) as well as the Benefits Website **www.MyWolterKluwerBenefits.com**.
- **Have the Following Information Available:**
    - Your user ID and password for Your Benefits Resources (if you've already established one);
    - The names, birthdates, Social Security numbers, and addresses of your spouse, *domestic partner*, and/or dependents (if you're enrolling them for coverage); and
    - If an HMO is available to you and you're electing HMO coverage, be sure to have the names of the *primary care physicians (PCPs)* for you and your dependents (*PCP* designations are not required for certain HMO options). During Annual Enrollment, you may decide to re-enroll in your current HMO for the next *Plan Year*. If this is the case and you want to change your *PCP* for the following year, please make this change directly with your HMO.

      You can find *PCP* information by visiting the Your Benefits Resources website and choosing one of the Find a Doctor links on the site. This online tool can help you locate doctors, *hospitals*, and clinics in your area that participate in the Plan.

- **Enroll Your Dependents:** If you want to enroll your eligible dependent for coverage, be sure to actively select the dependents you want to cover under the Plan.
- **Know Your Options:** Once you have the above information available, you're familiar with the coverage options available, you know which family members you want to cover, and how much you'll pay, you can enroll.
- **Enroll Online:** Access the Your Benefits Resources website by logging on at **www.yourbenefitsresources.com/wolters_kluwer** from any computer with Internet access.
- **Create a User ID:** The first time you use the site, you'll need to register as a new user. You'll be prompted to enter the last four digits of your Social Security number, your date of birth, and potentially your zip code. You'll then be prompted to create a new user ID and password. You'll then enter this user ID and password each time you visit the site (your user ID replaces your Social Security number when accessing the site).
- **Follow the Prompts:** Follow the online instructions/prompts and complete your enrollment. If you select an HMO, you may also have to complete separate HMO enrollment-related forms provided by the HMO. Watch for the “Completed Successfully” message to appear on your screen.
- **Confirm Your Elections:** For your confirmation, be sure to print a copy of the “Completed Successfully” page, which summarizes your benefit elections. You'll want to keep a copy of this statement for your records.
- **Make Corrections:** After you review your confirmation statement, you may need to correct your benefit elections. If this is the case, you can do so as many times as necessary within your 31-day enrollment period by calling the Your Benefits Resources Customer Service Center.

Enrolling By Phone

When you're first eligible and during each Annual Enrollment, you may enroll for coverage by phone. You may opt for this method if you don't have Internet access or you need help during enrollment. Contact a Your Benefits Resources Customer Service Representative at **1-866-520-3280**. Customer Service Representatives are available from 8 a.m. to 8 p.m. Eastern time, Monday through Friday (except holidays).

Here are a few helpful hints if you're enrolling by phone.

- **Review Information:** Be sure to review the detailed information available on Your Benefits Resources (if you have Internet access) as well as Benefits Website **www.MyWolterKluwerBenefits.com**.
- **Have the Following Information Available for Your Call:**
    - Your user ID and password for Your Benefits Resources if you've already established one (you also can provide the last four digits of your Social Security number, date of birth, and zip code);
    - The names, birthdates, Social Security numbers, and addresses of your spouse, *domestic partner*, and/or dependents (if you're enrolling them for coverage); and
    - If an HMO is available to you and you're electing HMO coverage, be sure to have the names of the *primary care physicians (PCPs)* for you and your dependents (*PCP* designations are not required for certain HMO options).

      You can find *PCP* information by visiting the Your Benefits Resources website and choosing one of the Find a Doctor links on the site. This online tool can help you locate doctors, *hospitals*, and clinics in your area that participate in the Plan.

- **Know Your Options:** Once you have the above information available, you're familiar with the coverage options available, you know which family members you want to cover, and how much you'll pay, call a Your Benefits Resources Customer Service Representative to enroll.
- **Enroll by Phone:** Call the Your Benefits Resources Customer Service Center toll-free at **1-866-520-3280**.
- **Verify Your Identity:** You'll be asked to provide personal information to verify your identity. Your password is the same whether you access the Your Benefits Resources website or call the Your Benefits Resources Customer Service Center.
- **Follow the Prompts:** Follow the automated voice response prompts or connect with a Your Benefits Resources Customer Service Representative and complete your enrollment. If you select an HMO, you may also have to complete separate HMO enrollment-related forms provided by the HMO. Remember, you must complete your enrollment within the enrollment period.
- **Confirm Your Elections:** You'll automatically receive a confirmation of benefits statement. You'll want to keep a copy of this statement for your records. You'll receive a confirmation statement within seven to 10 business days of your request.
- **Make Corrections:** After you review your confirmation statement, you may need to correct your benefit elections. If this is the case, you can do so as many times as necessary within your 31-day enrollment period by calling the Your Benefits Resources Customer Service Center.

Enrolling When You're First Eligible and During Annual Enrollment

You receive enrollment information via email (or at home if no email address is available) when you're first eligible to participate. The information you receive is an extension of this SPD and includes all the details you need to enroll. You have 31 days from the day you're first eligible to enroll (your 31-day deadline is included with your enrollment information).

Each fall during the Annual Enrollment period, you have the opportunity to elect or change your coverage based on the available group health plan options. You may make your elections online or through the telephone (see “Enrolling Online” or “Enrolling by Phone”).

Irrevocable Election

When you make an election, that election remains in effect for that *Plan Year*. Elections made during Annual Enrollment are effective for the following *Plan Year*. You're unable to change your election in the Plan until the next Annual Enrollment, unless you experience a qualifying life event and decide to change your elections.

Enrollment Pursuant to a QMCSO

You may become subject to a Qualified Medical Child Support Order (QMCSO) that requires you to provide medical coverage for a child. If this is the case, you or the Company may enroll a dependent child for medical coverage pursuant to the terms of a valid QMCSO. A child who's eligible for coverage pursuant to a QMCSO may not enroll his or her dependents for coverage under the Plan.

The Plan Administrator must first determine that the medical support order is “qualified” in order to change your coverage and enroll your child. The coverage change takes effect as of the date coverage is required under the QMCSO, as determined by the Plan Administrator. Coverage under the Plan is subject to payment of the required contribution unless, in the case of a child who's eligible for coverage pursuant to a QMCSO, payment of the required contribution is made by a state agency. The Company may withhold from your paycheck any required contributions for this coverage and send the contributions directly to the Plan.

You must notify the Company when you have completed your obligations under the QMCSO. The coverage for your child will end on the earlier of the date such coverage is no longer required under the QMCSO, or the date your child ceases to otherwise be eligible for dependent coverage under the Plan. However, if your child is otherwise a dependent who is eligible to be covered under the Plan, you may affirmatively elect to continue coverage for your child by electing continued coverage in accordance with the Plan enrollment rules described above. If you fail to make an affirmative election to continue coverage in a timely fashion, coverage will automatically end. The Plan's eligibility and Coordination of Benefit (COB) rules also will apply.

Coverage Category

For each coverage option, you can choose the level of coverage that fits your needs. The following coverage categories apply for each coverage option under the Plan.

- Employee Only
- Employee and Spouse
- Employee and Child(ren)
- Employee and Family
- No Coverage

The coverage category you elect remains in effect for the *Plan Year* (unless you elect to change your coverage based on a qualifying life event or other applicable change event during the *Plan Year*). See the “When You Can Change Coverage” main section for details.

If You Don't Enroll

If you don't enroll when you're first eligible or during Annual Enrollment, here's what happens.

- **Newly Eligible Enrollment:** If you don't enroll within 31 days of the date you're first eligible, you will default to “no coverage” and you and your eligible dependents must wait until the next Annual Enrollment period to enroll for medical (including prescription drug) coverage, unless you experience a qualifying life event or another applicable change event that entitles you to special enrollment rights. See the “When You Can Change Coverage” main section for details.
- **Annual Enrollment:** If you're enrolled for medical coverage but don't enroll during the next *Plan Year's* Annual Enrollment period, your coverage for the following year defaults to the coverage in effect (at the same coverage category level) during the previous year (at the coverage option's new price—provided that coverage option is still available to you). If you're not enrolled for medical coverage and don't enroll during the next *Plan Year's* Annual Enrollment period, you and your eligible dependents must wait to enroll until the next Annual Enrollment period, unless you experience a qualifying life event or another applicable change event that entitles you to special enrollment rights. See the “When You Can Change Coverage” main section for details.

Remember, when you first become eligible and prior to each Annual Enrollment, you receive important enrollment-related information. This information details the required enrollment process. Be sure to reference this information.

ID Cards

Once you enroll and become a Plan participant, you receive an ID card at your home address. You receive one ID card for your medical and prescription drug coverage (in your name only). You can request additional cards for other family members, if necessary).

The ID cards include your identification number. Some *providers* require that you show your ID card prior to treatment. Therefore, your card is very important. Be sure to present your ID card to your *provider* at the time you receive services. Your card can ensure that you receive the accurate level of benefits and pay the correct *copays* or *coinsurance* under the Plan (provided you adhere to all other Plan requirements). It may also potentially simplify and expedite the *claims* process.

If you or a covered family member misplaces a card, you can obtain another card by contacting the *claims administrator*. See the “Whom to Contact With Questions” main section for contact information relative to the *claims administrator*.

When Coverage Begins

Overview

When coverage begins depends on whether you're a regular *Full-* or *Part-time Employee*.

- **Full-time Employee:** As long as you meet the eligibility, enrollment, and contribution requirements, coverage begins on your first day of *active work*. Your first day of *active work* is also considered your eligibility date.
- **Part-time Employee:** As long as you meet the eligibility, enrollment, and contribution requirements, coverage begins once you complete one *year of service* with the *Company*. The day you meet the service requirement is considered your eligibility date.

If you're not at *active work* for any reason other than your *illness* or *hospital confinement* when coverage is scheduled to begin, coverage begins your first day of *active work* after you have satisfied all eligibility requirements. In no event does your coverage or your *year of service* begin until you've reported to work on your first day of employment.

Coverage for your eligible dependents begins on the same day as your coverage begins, or on the day your dependent first becomes eligible (whichever is later). See the “When You Can Change Coverage” main section for details regarding adding a dependent to coverage.

Remember, you must meet the eligibility and enrollment requirements and contribute toward the cost of coverage. The *Company* shall begin withholding contributions from your paycheck beginning with the first pay period after you enroll for coverage under the Plan (or the first pay period effective with the new *Plan Year* in the case of an Annual Enrollment election). Coverage takes effect when your election is made and is retroactive to your eligibility date.

Cost of Coverage

Overview

Regardless of the coverage option you select—one of the Blue Cross Blue Shield National coverage options (the Blue Cross Blue Shield Enhanced HSA, Core HSA, or the PPO Plan), or an HMO—you and the *Company* share the cost of coverage for you and your eligible dependents. This section highlights important cost information. Please also see the “Administrative Information” main section for which of the Plan's coverage options are self-insured and which are fully insured.

Paying With Pre-Tax Dollars

You and the *Company* share the cost of your and your eligible dependents' medical coverage. As an active participant, your cost is deducted from your paycheck each pay period on a pre-tax basis. If your *domestic partner* is enrolled for coverage, you pay for your *domestic partner's* coverage on an after-tax basis, unless your *domestic partner* qualifies as a tax dependent under the Internal Revenue *Code*.

If you're on a disability leave or an unpaid leave of absence and you want your coverage to continue, your contributions must continue as well. The Plan doesn't waive employee coverage contributions in such instances. If you're receiving Short-Term Disability (STD) Plan benefits, your contributions continue to be deducted from your paychecks. If you're on an unpaid leave of absence, you're billed for your continued medical coverage by Your Benefits Resources. If you don't pay the necessary contributions for coverage you want to continue under the Plan by the first of the month, coverage under the Plan terminates. See “Instances When Coverage May Continue” under the “How Long Coverage Continues” main section for more information.

You receive cost information for the upcoming *Plan Year* when you're first eligible and prior to the Annual Enrollment period. You also can obtain information regarding coverage costs online via the Your Benefits Resources website.

Using pre-tax dollars reduces your taxable income for federal, Social Security, and (in most cases) state income taxes. Pre-tax deductions don't affect the amount of your income when determining your benefits under other WKUS benefit plans.

Please note: Using pre-tax dollars can affect Social Security benefits you may eventually receive. This is because you don't pay Social Security (FICA) taxes on pre-tax dollars. For most people, the Social Security benefit reduction is just a few dollars a month. In addition, the reduction is typically more than offset by the tax savings you experience over the course of your career. If you have any concerns, or if you need additional information, contact your local Social Security Administration office or speak with a tax advisor.

How Cost Is Determined

You and the *Company* share the cost of your medical (including prescription drug) coverage. The amount you pay is based on your annual benefit base salary, the number of family members you enroll (coverage category), the coverage option you select, and the tobacco user status for you and any covered family member. The *Company* determines contribution amounts each year.

Your annual benefit base salary is determined on August 31 of each year and is applied January 1. If you're a non-commissioned employee, your annual benefit base salary is equal to your annual base pay. If you're a commissioned employee, your annual benefit base salary is equal to your annual base pay and commissions paid over a 52-week period (September 1 and August 31).

The information that you receive when you're first eligible and prior to each Annual Enrollment shows the per-pay-period cost of each coverage option available to you for the upcoming *Plan Year*. You also can obtain this information online via the Your Benefits Resources website.

Non-Tobacco User Credit

If you and your covered dependents pledge that you're non-tobacco users when you enroll online, the *Company* will give you a $600 annual credit. This credit is automatically applied toward the cost of your medical premium and is prorated for mid-year enrollments. (You also receive more favorable life insurance rates.) You must attest to your non-tobacco user status when you’re first eligible and each year during Annual Enrollment in order to receive the credit.

Costs Can Change

The *Company* reserves the right to change the costs that you and your dependents pay for coverage at any time and for any reason. Changes could include requiring you and your dependents to pay more for the cost of coverage, reducing credits, etc.

Tax Implications and Information

Your eligible *domestic partner* and *domestic partner's* child may be covered under the Plan regardless of whether they qualify under *Code* Section 152 as your tax dependent. If this is the case, the *Company* must include in your reportable income the cost of any medical coverage the *Company* provides to such individuals.

Therefore, before you enroll your *domestic partner* and *domestic partner's* child for medical coverage, you may want to check with a tax advisor to determine how these additional benefits may affect your personal tax situation. Different rules may apply for state income tax purposes.

When You Can Change Coverage

Overview

Because of the tax advantages associated with the Plan, the Internal Revenue Service (IRS) limits your ability to make changes to your coverage after initial enrollment to certain circumstances.

In general, once you enroll for (or decline) medical coverage, your election remains in effect for the entire *Plan Year*. However, under certain limited circumstances, you may enroll for or change coverage during the year. This main section highlights the types of events that allow you to make changes to your coverage during the *Plan Year*.

For more details about qualifying life events and other applicable change events, see the Your Benefits Resources website, or call the Your Benefits Resources Customer Service Center at **1-866-520-3280**.

Qualifying Life Events (QLEs)

You may change your medical coverage during the year if you experience a QLE that results in a loss or gain of eligibility for coverage under the Plan for yourself, your spouse, your domestic partner, or your eligible dependent children. A change may be made as long as it's on account of and consistent with the QLE (the change must also follow the Plan's rules). A QLE is any of the following circumstances that may affect coverage.

- You get married or establish an eligible *domestic partnership*.
- You get divorced, legally separated, have your marriage legally annulled, or dissolve a *domestic partnership*.
- Your spouse/*domestic partner* dies.
- You have a baby, adopt, or have a child placed with you for adoption.
- Your dependent child dies.
- You, your spouse/*domestic partner*, or your dependent experiences a change in employment status that affects coverage in the Plan or your spouse's/*domestic partner's* or dependent's employer's plan, including:
    - The start or end of employment;
    - A switch from *Part-time Employee* to *Full-time Employee* status (or vice versa);
    - A strike, lockout, or layoff;
    - The start or return from an unpaid or significantly reduced paid leave of absence;
    - A change in work site; or
    - Any other change in employment status that affects your, your spouse's/*domestic partner's*, or your dependent's medical coverage.
- Your dependent child becomes eligible or ineligible for coverage (i.e., he or she reaches the Plan's eligibility age limit or other applicable circumstance).
- A change in the eligibility provisions of your spouse's/*domestic partner's* or dependent's employer's benefit plan.
- Your, your spouse's/*domestic partner's*, or your dependent's home address changes (which affects coverage).
- You, your spouse/*domestic partner*, or your dependent experiences any other event that's recognized under applicable law and regulations as a reason to change a medical coverage election under the Plan.

If you want to change your medical coverage during the *Plan Year* due to a QLE and learn when the new coverage change takes effect, see “How to Make a Mid-Year Change” under this main section for details.

Other Applicable Change Events

You may make a change under the Plan due to one of the following events.

HIPAA Special Enrollment

You may decline medical coverage under this Plan for yourself and/or your eligible dependents (including your spouse/*domestic partner*) because you have medical coverage under another health insurance option or group health plan. If you do and you acquire a new dependent due to marriage, birth, adoption, or placement for adoption, you qualify for a special enrollment opportunity under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). As a result, you have the right to enroll yourself and/or your eligible dependents mid-year and pay the contributions for medical coverage under the Plan on a pre-tax basis.

You also qualify for the special enrollment if you or your eligible dependents lose coverage under another group health plan for any of the following reasons:

- You or your dependents exhaust *Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)* coverage under another employer's group health plan (other than due to failure to pay contributions, or for cause). You must have been covered under *COBRA* for the maximum time period available to you.
- Another employer was previously contributing toward the cost of the other group health plan coverage that is **not** *COBRA* coverage and has terminated the employee contributions for that coverage.
- You or your dependents are no longer eligible for coverage under the other group health plan (that is not *COBRA* coverage). “Loss of eligibility” includes a loss of coverage due to:
    - Legal separation, divorce, or dissolution of *domestic partnership*;
    - Your or your dependent's death;
    - A dependent who no longer satisfies a plan's definition of an eligible dependent;
    - Termination of employment or reduction in the number of hours of employment;
    - A loss of HMO coverage because you or your dependent no longer resides or works within the HMO service area and no other coverage option is available; or
    - A plan that no longer offers benefits to you or your dependent.

    Loss of eligibility doesn't include the loss of coverage because you fail to timely pay required employee contributions, or you lose coverage for cause (i.e., fraud or intentional misrepresentation).

Under the Children's Health Insurance Program Reauthorization Act (CHIP), employer-sponsored group health plans are required to update their mid-year special enrollment period rules. If you or your dependent is eligible, but not enrolled, for coverage under the Plan, you're eligible to enroll for coverage if you meet either of the following conditions and you request enrollment with the Plan no later than 60 days after the date of the event:

- You or your dependent loses eligibility for *Medicaid* or CHIP coverage; or
- You or your dependent becomes eligible for premium assistance, with respect to coverage under the Plan, due to coverage with *Medicaid* or a state child health plan.

To request special enrollment or obtain more information, you should contact the Your Benefits Resources Customer Service Center.

If you want to change your medical coverage due to a special enrollment event that qualifies under HIPAA and learn when the new coverage change takes effect, see “How to Make a Mid-Year Change” under this main section.

Qualified Medical Child Support Order (QMCSO)

To the extent required by the terms of a judgment, decree, or *Qualified Medical Child Support Order (QMCSO)*—and subject to procedures established by the Plan Administrator—you may change your medical coverage election under the Plan to provide coverage to a dependent in accordance with the terms of a QMCSO. The Plan Administrator will furnish QMCSO procedures at no charge per your request. These procedures describe the process that's followed when determining whether an order is a QMCSO. The effective date of coverage will be the date coverage is required under the QMCSO, as determined by the Plan Administrator.

You must notify the *Company* when you have completed your obligations under the *QMCSO*. The coverage for your child will end on the earlier of the date such coverage is no longer required under the *QMCSO* or the date your child ceases to otherwise be eligible for dependent coverage under the Plan. However, if your child is otherwise a dependent who is eligible to be covered under the Plan, you may affirmatively elect to continue coverage for your child by electing continued coverage in accordance with the Plan enrollment rules described above. If you fail to make an affirmative election to continue coverage in a timely fashion, coverage will automatically end. The Plan's eligibility and Coordination of Benefit (COB) rules also will apply.

If a QMCSO requires your spouse, your former spouse, or another individual to provide coverage for your dependent child, and that coverage is, in fact, provided, you may cancel coverage under this Plan for that child within 31 days following the effective date of the other coverage by contacting the Plan Administrator. The contribution change takes effect as of the effective date of the QMCSO.

For additional information regarding changing your enrollment election in response to a QMCSO, see “How to Make a Mid-Year Change” under this main section.

Significant Cost or Coverage Change

You also may change your medical coverage under the Plan during the year if:

- There's a significant change in the availability of coverage or the cost (20% increase in cost) of your medical coverage under the Plan, but only if you elect another similar coverage instead or you drop coverage. For example:
    - A similar coverage option is added or is significantly improved and you're eligible for such coverage option.
    - An event occurs that significantly curtails your, your spouse's/*domestic partner's*, or your dependent's coverage or causes you to lose medical coverage under your current coverage option (e.g., there's an overall coverage reduction to all participants).

- You, your spouse/*domestic partner*, or your eligible dependent loses coverage under any group health coverage that's sponsored by a governmental or educational institution.
- The change corresponds with a change made by you, your spouse/*domestic partner*, or your dependent under another employer's plan due to the following:
    - The Annual Enrollment period under the other plan is different from this Plan's Annual Enrollment period;
    - The other plan has a different *Plan Year* than this Plan; or
    - The other employer's plan allows you, your spouse/*domestic partner*, or your dependent to change elections due to the reasons described in this section (i.e., QLE, special enrollment due to HIPAA, *QMCSO*, and significant cost or coverage changes).

See “How to Make a Mid-Year Change” under this main section for details on how to change your medical coverage due to the above.

Medicare or Medicaid Entitlement

You or your spouse/*domestic partner* may gain or lose *Medicaid* or *Medicare* (Part A or B) coverage. If this is the case, you may change your medical coverage under this Plan accordingly. You must request such a change within 31 days of the gain or loss of coverage (60 days for Medicaid). The coverage/contribution change takes effect on the first day of the month after the Plan Administrator's approval.

How to Make a Mid-Year Change

If you experience a QLE or other applicable change during the *Plan Year* and want to change your medical coverage, you can make your change online via the Your Benefits Resources website, or by phone via the Your Benefits Resources Customer Service Center. **Regardless of which method you choose, you must make the necessary updates within the 31-day period**. Your change in coverage is approved only if it's consistent with the QLE or other applicable change event and it follows Plan rules.

When the change in coverage takes effect depends on the type of change.

- **Qualifying Life Events (QLEs):** The election or change in coverage and applicable contribution take effect as of the date of the QLE you process online via the Your Benefits Resources website or by phone via the Your Benefits Resources Customer Service Center provided you request the election or change within 31 days of the QLE.
- **Other Applicable Change Events:** The change in coverage takes effect as follows:
    - **HIPAA Special Enrollments:** Provided you request the coverage change within 31 days of the special enrollment event, the new coverage takes effect (1) in the case of a dependent's birth, adoption, or placement for adoption, retroactive to the date of the special enrollment event; (2) in the case of marriage, not later than the first day of the month beginning after the request for enrollment is made.

- **Qualified Medical Child Support Order (QMCSO):** The new (adding of) coverage takes effect on the later of date coverage is required under the *QMCSO* or the date the order is qualified by the Plan Administrator. The coverage for your child will end on the earlier of the date such coverage is no longer required under the *QMCSO,* or the date your child ceases to otherwise be eligible for dependent coverage under the Plan. However, if your child is otherwise a dependent who is eligible to be covered under the Plan, you may affirmatively elect to continue coverage for your child by electing continued coverage in accordance with the Plan enrollment rules described above. If you fail to make an affirmative election to continue coverage in a timely fashion, coverage will automatically end.

If you experience a QLE or other applicable change event and you don't request a coverage change within the 31-day period, you must wait until the next Annual Enrollment period (unless you once again experience a QLE or other applicable change event).

How Your Coverage Works

Overview

This section provides an overview of how your coverage works, including information about your coverage options, how the Plan pays benefits, Blue Cross Blue Shield Customer Service, and special programs related to *surgery*.

About Your Blue Cross Blue Shield National Coverage Options

Your Blue Cross Blue Shield National coverage options include:

- Blue Cross Blue Shield Enhanced HSA;
- Blue Cross Blue Shield Core HSA; and
- Blue Cross Blue Shield PPO Plan.

Here are a few highlights of these coverage options.

- The options give you access to a network of *physicians*, *hospitals*, and treatment facilities. The HSA options provide a means for you to receive an economic incentive as *eligible expenses* are reimbursed on a *negotiated fee* basis resulting in a lower cost to you and the *Company*. The PPO option provides a means for you to receive medical services at a lower cost to you and the *Company* when you use *network providers* who participate in the network and agree to charge lower *negotiated fees* for care.
- At the point that you require care ("point of service"), you choose your *provider*. You may see a *network* or *out-of-network provider* for care. You can select a *network provider* from the *provider Directory*.

You can find a *network provider* online via the Your Benefits Resources or the *claims administrator's* website, or you can call the Your Benefits Resources Customer Service Center directly at **1-866-520-3280**. You are urged to also check with your *provider* before you undergo treatment to make sure he or she still participates in the network.

- **Network Care:** If you receive care from a *network provider*, you will receive an economic incentive as *eligible expenses* are reimbursed on a *negotiated fee* basis resulting in a lower cost to you and the *Company*. Here are a few things to note regarding *network care*:
  - Your care is coordinated by your *physician* or *specialist*.
  - If your *physician* recommends hospitalization, he or she coordinates your admission. You or someone on your behalf must satisfy all preauthorization requirements. See "The Managed Care Program" main section for details.
  - To pay for HSA services, the Plan generally pays a higher *coinsurance* of *eligible expenses* based on *negotiated fees* once you satisfy your *deductible*. Your *deductible* requirement, however, may be higher than you have experienced under similar health plans.
  - To pay for PPO services, you must meet a *copay* requirement, then the Plan pays a percentage of *eligible expenses* based on *negotiated fees* once you satisfy your *deductible.* Your share of *negotiated fees* is called your *coinsurance*. Once you reach the out-of-pocket maximum (your medical *copays*, *deductible* plus *coinsurance* amounts), the Plan pays benefits at 100% of *eligible expenses*.

- You don't need a referral. You can refer yourself to a network *specialist*. In addition, you don't have to select a *primary care physician* to coordinate your care.
- In an emergency, go to the nearest emergency room for treatment—even if it's outside the network. If you're treated and released, the Plan pays a percentage (for example, 80% for the PPO option) of *negotiated fees* for *eligible expenses* (after the *deductible*). The Plan does not pay benefits for use of the emergency room for a non-emergency situation.
- You generally don't have to file a *claim* before the Plan pays benefits.

- **Out-of-Network Care:** You can see an *out-of-network provider* for care. If you do, the Plan reimburses you for *eligible expenses* based on a *maximum allowance* charge typically resulting in a higher cost to you and the *Company*.

  Here are a few things to note regarding *out-of-network care* for the HSA and PPO options:

  - You can receive care from a *physician* or facility of your choice.
  - For certain services, like non-emergency hospitalization and *surgery*, you must meet preauthorization requirements. If you don't, penalties apply. Your *physician* or *specialist* can contact the *claims administrator* to preauthorize care on your behalf. Failure to do so may result in penalties. See “The Managed Care Program” main section for details.
  - The Plan pays a percentage of *eligible expenses* based on the *maximum allowance* once you satisfy your *deductible*, including *emergency medical care* if a true emergency.
  - Your share, a percentage of *eligible expenses,* based on the *maximum allowance* is called your *coinsurance*.
  - Once you reach the out-of-pocket maximum, the Plan pays 100% benefits for *eligible expenses*.
  - The Plan pays benefits based on the *maximum allowance* charge. As a result, you're responsible for charges that exceed *maximum allowance* limits. These expenses aren't eligible for Plan benefits.
  - You must file a *claim* before the Plan pays benefits.

For general information on how benefits are paid, see “How the Plan Pays for Benefits” under this main section.

See the snapshot charts for the Blue Cross Blue Shield coverage options for any *copays*, *deductibles,* or *coinsurance* that apply. The charts also include the percentage the Plan pays for each type of *covered service*.

The Blue Cross Blue Shield coverage options also include prescription drug coverage. See “The CVS Caremark Prescription Drug Program for the Blue Cross Blue Shield National Coverage Options” main section for details.

More Detail About the Enhanced and Core HSA Coverage Options

Due to the unique design of the coverage options, there are additional details to understand about how they work. Here are a few highlights of this coverage.

- The coverage offers a Health Savings Account (HSA) feature. This is a consumer-driven option that not only pays a percentage of *eligible expenses* (similar to a PPO), but includes an account that you can save and invest with to pay your share of covered medical expenses. This approach is designed to provide you with a base amount of coverage, as well as flexibility in how you decide to spend your health care dollars.
- At the beginning of each *Plan Year,* or an alternate schedule as specified, the *Company* allocates a specific dollar amount to your account. The amount you receive depends on the coverage category you select (Employee Only, Employee and Spouse, Employee and Child(ren), or Employee and Family). Note your Health Savings Account must be active to receive employer contributions. If any employer contributions are returned to the company, they will not be redeposited.
- In addition to *Company* contributions, you and your family members may contribute to your account on a pre-tax or after-tax basis at any time, unless you are enrolled in *Medicare*. All account funds become yours for your lifetime. In the event of your death, your account can pass to your surviving spouse without federal tax liability.
- You decide how to pay for your *eligible expenses*. You can use the HSA dollars first to pay for regular health care expenses and some expenses that may not be covered by the Plan (e.g., charges in excess of the *maximum allowance*, or the cost difference between a brand-name and *generic* prescription drug). The HSA dollars that you use also help you pay your *deductibles*.
- You're responsible for paying your medical expenses until you meet your *deductible*. Your *deductible* includes medical and prescription drug expenses. After you satisfy your *deductible*, you and the HSA options share the cost of your health care expenses.

  Under the Enhanced HSA, in-network expenses are shared 90% by the HSA, 10% you; out-of-network the Plan pays 70% of the *maximum allowance*, and you pay the other 30%. Under the Core HSA, in-network expenses are shared 70% by the HSA, 30% you; out-of-network the Plan pays 50% of the *maximum allowance*, and you pay the other 50%.
- *Preventive care* is covered by the Plan at 100% as long as services are in-network and billed as *preventive care*.
- If you enroll in an HSA, federal regulations do not allow you to enroll in a traditional Health Care Flexible Spending Account (FSA). However, you may use a limited purpose Health Care FSA to pay for qualified dental or vision expenses for you or your tax dependents. If you satisfy your annual medical *deductible*, the Health Care FSA can be used to help pay for qualified medical expenses incurred by you or your tax dependents. You may elect to make pre-tax contributions to the Wolters Kluwer Health Care FSA on a limited purpose basis. Please review the Flexible Spending Account Summary Plan Description for annual contribution and carry-over limits.
- If you or your dependent is *Medicare*-eligible, you are able to be reimbursed for covered expenses under the HSA. After you reach age 65, you may use your HSA funds for any expenses without penalty. However, the amount of any non-qualified distribution will be taxed as part of your gross income.

- The HSA has the potential to cover all medical expenses you may incur during the year. If you don't use all of the dollars allocated to your account, the remaining amount automatically rolls over to the next *Plan Year*. You don't forfeit any unused dollars left in your account at the end of the *Plan Year,* and there's no maximum on the amount you can roll over from one year to the next. As a result, your HSA may grow almost like a savings account. Remember that you own this account; therefore, you may be responsible for any fees charged by HSA Bank. You can review the balance of your HSA at any time by logging on to **www.hsabank.com**, or by contacting Customer Service at **1-800-357-6246**, Monday through Friday, 7 a.m. to 8 p.m. Eastern time.
- At the point that you require care, you choose your *provider*. You may see a *network* or *out-of-network provider* for care. You can select a *network provider* from the *provider Directory* located online through the Your Benefits Resources or *claims administrator's* website. You can also call the Your Benefits Resources Customer Service Center directly at **1-866-520-3280**. You are urged to also check with your *provider* before you undergo treatment to make sure he or she still participates in the network.
- A $5,000 Critical Illness policy, administered by MetLife, is provided to HSA enrollees (employee only) at no cost. The policy provides for a lump-sum payment if you're diagnosed with serious conditions such as cancer, kidney failure, or a stroke; to help offset your out-of-pocket expenses. You will receive a packet of information directly from MetLife 2-3 weeks after enrollment in the HSA plan. You also may be able to purchase additional coverage for yourself or your covered family members during Annual Enrollment subject to Underwriting by MetLife. Additional information can be found at **https://mybenefits.metlife.com**.

With one of the HSA coverage options, you can:

- Contribute automatically through pre-tax payroll deductions to reduce your taxable income;
- Use an HSA Bank Visa debit card to pay for eligible medical expenses from your account;
- Earn tax-free interest on your money;
- Invest in a wide variety of investment options to grow your account funds; and
- Take your HSA account with you even if you leave the Company or retire.

HSA Example #1

To show how this coverage option might help you pay the cost of your covered medical expenses, let's assume that you enroll in the Enhanced HSA option with Employee Only coverage when you enroll, and the *Company* contributes $800 in HSA dollars to your account for the upcoming *Plan Year*. During the *Plan Year*, let's also assume you incur the following expenses:

- $200 in routine *preventive care* (all *network care*); and
- $500 in other covered medical expenses (office visits, lab work, procedures, and prescription drugs).

Since you received *preventive care* from a *network provider*, the Plan pays the full cost of the care with no deduction from your HSA, and you are billed for the $500 of other covered medical expenses. You may choose to use your HSA to pay for the expense or use other personal assets and allow your HSA to accrue. Because you didn't use all of your benefit dollars in your account, the remaining $300 remains in your account for future use.

Note that if you are re-hired within the same Plan Year and the same coverage category, you will not receive an additional employer contribution. If you enroll in a higher coverage category, you will receive the contribution amount for the higher coverage category.

HSA Example #2

If you are a plan participant and you become enrolled in Medicare (Part A or Part B) and you choose not to dis-enroll or defer your Medicare enrollment, you are no longer eligible to make or receive contributions to your HSA. Your maximum contribution to your HSA in the *Plan Year* in which you enroll in Medicare is determined as follows:

Let's assume that you enroll in Employee and Spouse coverage, your maximum Enhanced HSA contribution (employee plus employer) is $7,000, and you are eligible to make a catch-up contribution of $1,000. You will be enrolled in Medicare as of May 1, meaning there were four months of contribution eligibility. You are able to make or receive contributions of up to $666.67 per month ($8,000/12 months) for a total of $2,666.68 (between January 1 – April 30), which is the maximum amount that your account could receive before being deemed an excess contribution, including both employer and employee contributions.

If your covered spouse enrolls in Medicare, there will be no impact to your eligibility to make or receive contributions to the HSA.

If you anticipate you will exceed the maximum, please contact HSA Bank to obtain an Excess Contribution Form. Monies must be withdrawn before December 31.

HSA Example #3

Let's assume that a newly eligible employee elects the Enhanced HSA on February 1. Contributions are made in the next quarter following your plan election:

- April: $200
- July: $200
- October: $200
- **Total Contribution: $600**

Important: If you make an election to participate in the Plan midyear, you must enroll in the HSA coverage option the following year.

HSA Example #4

To show you how it works when you change/increase your coverage category, let's assume that you increase your coverage category from Employee Only to Employee and Spouse coverage. Let's assume that you enroll for Employee Only coverage during Annual Enrollment and receive a contribution to your Enhanced HSA in the amount of $800 annually (contributions may be made quarterly or semi-annually). On February 1, let's assume you marry and add your spouse to coverage ($1,400 annually). As a result, you move to Employee and Spouse coverage and receive a contribution to your HSA for that coverage category. Here's what happens:

- **Employer Contribution (from January 1 through March 31):** The annual amount contributed in your HSA is $800 for the *Plan Year*, $200 payable in January.
- **Employer Contribution (from April 1 through December 31):** The additional amount contributed to your HSA is $1,050; therefore, your total contribution for the *Plan Year* would be $1,250; $350 payable in April, July, and October.

HSA Example #5

To show you how it works when you change/decrease your coverage category, let's assume that during Annual Enrollment you enroll for Employee and Family coverage and receive a contribution to your Enhanced HSA in the amount of $1,600 annually (contributions may be made quarterly or semi-annually). On February 1, let's assume you experience a QLE and change to Employee Only coverage. Here's what happens:

- **Employer Contribution (from January 1 through March 31):** If quarterly, the contribution would be $400.
- **Employer Contribution (from April 1 through December 31):** The additional amount contributed to your HSA is $600; therefore, your total contribution for the *Plan Year* would be $1,000; $200 payable in April, July, and October.

HSA Example #6

To show you how it works when you terminate employment, let's assume that you enroll for Employee and Family coverage and receive a contribution to your Enhanced HSA in the amount of $1,600 annually. On April 1, you terminate employment with the *Company* and you don't elect to continue coverage under *COBRA*. Let's also assume that your covered dependents do elect to continue coverage under *COBRA*. Here's what happens:

- **Employer Contribution (from January 1 through March 31):** If quarterly, the contribution would be $400.
- You retain your HSA account, but all employer and employee contributions end as of your termination date. You may elect to keep your account with the current administrator or transfer it to another financial institution. Please note that there may be additional fees for account maintenance.
- Any payment from the HSA that occurred before your termination in employment remains a part of your HSA (whether incurred by you or your dependents).
- Your dependents who elect *COBRA* receive a new *deductible* based on who enrolls in *COBRA*. HSA accounts are not available for *COBRA* participants who were not Wolters Kluwer employees.

About the HMO Options

Here's some information about HMO coverage.

- An HMO is an organization of *physicians*, *hospitals*, and other *providers* that finance and deliver health care services. If you receive care from an HMO *provider*, you generally have to meet a *copay* requirement before the Plan pays benefits. A *deductible* also may be required, but you generally have minimal out-of-pocket costs under this option.
- The *Company* offers HMO coverage options in some areas. Depending on where you live, you may be able to select an HMO as your medical coverage option. If an HMO is offered where you live, it's listed as a coverage option on your enrollment information.
- As an HMO participant, you have access to a network of *physicians*, *hospitals*, and other health care *providers* that agree to provide health care services at *negotiated fees*.

- Most HMOs require that a *primary care physician (PCP)* coordinate your care. Your *PCP* is your general practitioner whom you go to see first. Then, if you need a referral to a *specialist*, your *PCP* can take care of the referral.

  If you select HMO coverage, you may need to select a *PCP*. If you do, make sure you obtain the list of *PCPs* and their *provider* numbers available to you via the Your Benefits Resources website. You may need to list a *PCP* for each family member whom you enroll.
- If you receive care from an HMO *provider*, the Plan generally pays 100% of *eligible expenses* based on *negotiated fees* (after a *copay*) and you may have an annual *deductible* requirement. If you receive care from a non-HMO *provider*, the Plan generally doesn't cover those medical expenses.
- If you receive care from an HMO *provider*, you generally have few or no claim forms to file for benefits.
- When you enroll in an HMO, you're deciding to use only that HMO's *providers* for the entire year. Consequently, if you receive care from a *provider* outside the HMO network, the Plan doesn't pay benefits.

If you select HMO coverage, the HMO offers prescription drug coverage. Contact your HMO directly regarding details of this coverage.

How the Plan Pays Benefits

Depending on the coverage option you select and whether you receive *network* or *out-of-network care*, a *copay*, annual *deductible*, *coinsurance*, or annual out-of-pocket maximum may apply. See your coverage option's snapshot chart for details.

Remember, if you select an HMO option, refer to your HMO materials for details. The SPD issued by your HMO highlights how your particular HMO coverage option pays benefits and what services are excluded.

Here's some important information regarding how the Plan pays benefits under the Blue Cross Blue Shield National coverage options.

Deductibles

The *deductible* is the fixed dollar amount you pay each year before the Plan pays benefits. The snapshot charts detail the *deductibles* that apply for your coverage option.

If you select an HSA option, your account dollars may be used toward the cost of your annual *deductible* requirement.

Under the Enhanced HSA, the individual *deductible* applies separately to each covered individual, and the family *deductible* applies collectively to all covered persons in the same family. Once you meet the family *deductible*, however, your remaining covered individual family members don't have to meet their individual *deductible* for the rest of that year. So, if your family coverage includes you and one dependent, you and your dependent need to satisfy one family *deductible* but the family *deductible* can be satisfied with eligible expenses from a single family member.

Under the Core HSA, the individual *deductible* applies separately to each covered individual. Covered expenses for each individual are added together to meet the family *deductible.* Once a covered individual meets his or her individual *deductible*, the HSA option begins paying benefits for eligible expenses.

If you participate in the Blue Cross Blue Shield PPO option, one single family member can't satisfy more than the individual *deductible* amount toward the family *deductible*.

Copays

A *copay or copayment* is a fixed dollar amount that you may pay at the time of service for certain services before the Plan pays benefits. If you participate in the Blue Cross Blue Shield PPO coverage option, or an HMO coverage option, *copays* apply for *physician* office visits and prescription drug services. See your coverage option's snapshot charts for the medical services that require a *copay*, as well as "The CVS Caremark Prescription Drug Program for BCBS Options" main section for the *copays* that apply for prescription drug services.

Medical copays don't apply toward your *deductible* requirement or *coinsurance*.

Coinsurance

Coinsurance is the percentage of the *eligible expense* that you and the Plan are responsible for paying. Percentages apply after any applicable *deductible* requirement. The amount you pay depends on the coverage option you select and whether you receive *network* or *out-of-network care*. See your coverage option's snapshot charts for the percentage the Plan pays for each type of *covered service*.

Annual Out-of-Pocket Maximums

The out-of-pocket maximum is the most you have to pay out of pocket for *eligible expenses* in one *Plan Year*. The out-of-pocket maximum amount includes your medical *copays*, *deductible* and *coinsurance* requirement and depends on the coverage option and health care *provider* you select. See your coverage option's snapshot charts for the out-of-pocket maximums that apply.

Once you reach the annual out-of-pocket maximum, the Plan pays 100% of *eligible expenses* for the remainder of the *Plan Year*. Depending on the coverage category you select, an individual or family out-of-pocket maximum applies. If you participate under the Enhanced HSA, one single family member can satisfy the family out-of-pocket maximum. However, under the Core HSA or the PPO option, one single family member can't satisfy more than the individual out-of-pocket maximum amount toward the family out-of-pocket maximum. For any remaining covered family members, their eligible expenses apply to meeting the remaining out-of-pocket maximum for the tier of coverage selected.

Certain charges **don't** apply toward the out-of-pocket maximum. These include:

- Penalties or any additional expense that may apply because you don't meet certain preauthorization requirements; and
- Any expense that's not considered an eligible expense, is above the negotiated fee, is in excess of the maximum allowance charge, or exceeds other Plan limits.

In addition, an annual prescription drug expense out-of-pocket maximum applies **under the PPO option**. Once you reach this out-of-pocket maximum, the PPO option generally will pay 100% of your prescription drug costs for the rest of the year. This out-of-pocket maximum is separate from the medical out-of-pocket limits that are in place.

Benefit Maximums

For certain services, the Plan limits benefits. See your coverage option's snapshot charts for the benefit limits that apply to certain *covered services*.

There is no lifetime limit on the dollar value of benefits under the Plan.

Blue Cross Blue Shield Customer Service

Blue Cross Blue Shield Customer Service is a toll-free number provided through the *claims administrator*—Blue Cross Blue Shield. The toll-free number is **1-877-238-5944** (also included on your ID card) and is available Monday through Friday between 7 a.m. and 8 p.m. Central time.

You can use Blue Cross Blue Shield Customer Service to:

- Preauthorize certain care, including but not limited to:
  - *Inpatient hospital* admissions;
  - *Inpatient* behavioral health and *substance abuse* treatments;
  - *Emergency admissions*;
  - Maternity admissions; and
  - Alternative *hospital* care (*private duty nursing*, home health care services, services in a convalescent home).

  Failure to follow preauthorization requirements can result in financial penalties. See "The Managed Care Program" main section for details.

- Get advice regarding alternative *hospital* care, including hospice stays, *private duty nursing*, home health care services, and *convalescent care facilities*.
- Verify benefit amounts available.
- Check on the status of a benefit *claim*.
- Request *provider* directories.
- Obtain general health information.

Blue Cross Blue Shield also offers the Blue Cross Blue Shield 24/7 Nurseline. This toll-free number provides you access to health care professionals who staff the line 24 hours a day, seven days a week. You can reach the Blue Cross Blue Shield 24/7 Nurseline by calling **1-800-299-0274** (this number is also included on your ID card).

Blue Cross Blue Shield Blue Distinction Centers

Blue Cross Blue Shield Blue Distinction Centers are centers of excellence for transplant, bariatric surgery, knee/hip replacement, spine, cardiac care and rare cancers. Blue Distinction Centers consistently achieve higher quality of care through better outcomes, fewer complications and lower re-admission rates. Because of this, a higher benefit is payable for utilizing a Blue Distinction Center and is required for certain procedures to receive a benefit. See your coverage option's snapshot charts for the benefits payable.

MDLIVE

Medical needs can happen at any time, anywhere. MDLIVE is your medical companion when you need it most. The mobile app, website (**www.mdlive.com/bcbsi**l) and telephone (**1-888-676-4204**) service offers virtual office visits 24 hours a day, seven days a week, for non-emergent conditions such as fever, allergies, asthma, rash, pink eye and cold/flu symptoms; as well as dermatology visits.

Specialists aligned with MDLIVE have an average of 15 years' experience and can provide medically necessary prescriptions to your local pharmacy.

Confidentiality is part of MDLIVE's Code of Ethics. It takes your privacy very seriously. The HIPAA Privacy Rule is designed to be a minimum level of protection and some states have even stricter laws in place to protect your personal health information. MDLIVE can share your information with your PCP in accordance with applicable state and federal laws.

Registration takes less than 15 minutes (via smartphone, laptop or computer), note you will need your BCBSIL ID number. Once you have an account, you can access free tips on how to use telemedicine and you can book an appointment at any time.

What the Plan Covers

Overview

Regardless of the coverage option in which you're enrolled, the Plan pays benefits for *covered services* if medically necessary only. In addition, the Plan only pays benefits for *eligible expenses* incurred while coverage is in effect. The Plan doesn't pay benefits for expenses incurred before or after the coverage effective date—even if the expense is incurred to treat an *accident*, *illness*, or *injury* that occurs while coverage is in effect (an expense is considered incurred on the date the service or supply is furnished).

When determining whether or not a service is an eligible expense, the Plan considers if the service is medically necessary for the care and treatment of the *illness* or *injury* and provided upon the direction or under the direct care of your *physician*. It then pays benefits based on the *negotiated fee* or *maximum allowance* charge depending on whether you receive *network* or *out-of-network care*. The Plan also considers whether you have coverage from other sources so that it may coordinate benefits. See the "Coordination of Benefits (COB)" main section for details.

The snapshot charts detail how the Plan pays benefits for each type of *covered service* (including any benefit limits, *copays*, or *deductible* requirements that may apply). This main section describes the types of services the Plan covers. These services are subject to all terms and conditions of the Plan, which are summarized here. Be sure to also reference the "What the Plan Doesn't Cover" main section for various limits, exclusions, and/or special conditions that pertain to Plan benefits. "The Managed Care Program" main section also details the steps you need to take to satisfy preauthorization requirements to avoid financial penalties.

Remember, if you participate in an HMO coverage option, separate materials issued by your HMO detail the terms and conditions regarding your *covered services*. Please reference those separate materials for details.

Hospital Services

The Plan pays benefits for the following *hospital* services.

Inpatient Hospital Care

The following are *covered services* when you receive them as an *inpatient* in a *hospital*.

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

Preadmission Testing

Benefits are provided for preoperative tests given to you as an *outpatient* to prepare you for *surgery* which you are scheduled to have as an *inpatient*, provided that benefits would have been available to you had you received these tests as an *inpatient* in a *hospital*. Benefits will not be provided if you cancel or postpone the *surgery*. These tests are considered part of your *inpatient hospital* surgical stay.

Partial Hospitalization Treatment

Benefits are available for this program only if it is a *claims administrator*-approved Program. No benefits will be provided for services rendered in a *partial hospitalization treatment program* which has not been approved by the *claims administrator*.

Coordinated Home Care

Benefits will be provided for services under a *coordinated home care program*. You are entitled to benefits for 120 visits in a *coordinated home care program* per benefit period.

Outpatient Hospital Care

The following are *covered services* when you receive them from a *hospital* as an *outpatient*.

- *Surgery* and any related *diagnostic service* received on the same day as the *surgery*.
- Radiation therapy treatments.
- *Chemotherapy.*
- Electroconvulsive therapy.
- *Renal dialysis treatments*—if received in a *hospital*, a *dialysis facility,* or in your home under the supervision of a *hospital* or *dialysis facility*.
- *Diagnostic service*—when you are an *outpatient* and these services are related to *surgery* or *medical care.*
- Urgent care.
- *Emergency accident care*—treatment must occur as soon as reasonably possible.
- *Emergency medical care.*
- Bone mass measurement and osteoporosis—benefits will be provided for bone mass measurement and the diagnosis and treatment of osteoporosis.

Physician/Professional Services

The Plan pays benefits for the following *physician* and professional services.

Surgery

Benefits are available for *surgery* performed by a *physician*, *dentist*, or *podiatrist*. However, for services performed by a *dentist* or *podiatrist*, benefits are limited to those surgical procedures which may be legally rendered by them and which would be payable under this Plan had they been performed by a *physician*.

Benefits for oral *surgery* are limited to the following services:

- Excision of tumors or cysts of the jaws, cheeks, lips, tongue, and roof and floor of the mouth;
- Surgical procedures to correct accidental *injuries* of the jaws, cheeks, lips, tongue, and roof and floor of the mouth; and
- Excision of exostoses of the jaws and hard palate (provided that this procedure is not done in preparation for dentures or other prostheses); treatment of fractures of facial bone; external incision and drainage of cellulitis; incision of accessory sinuses, salivary glands or ducts; and reduction of dislocation of, or excision of, the temporomandibular joints.

The following services are also part of your surgical benefits:

- *Anesthesia services*—if administered at the same time as a covered surgical procedure in a *hospital* or *ambulatory surgical facility* or by a *physician* other than the operating surgeon or by a *Certified Registered Nurse Anesthetist*. However, benefits will be provided for *anesthesia services* administered by oral and maxillofacial surgeons when such services are rendered in the surgeon's office or *ambulatory surgical facility*. In addition, benefits will be provided for anesthesia administered in connection with dental care treatment rendered in a *hospital* or *ambulatory surgical facility* if
    - A child is age 6 or under;
    - You have a chronic disability; or
    - You have a medical condition requiring hospitalization or general anesthesia for dental care.
- Assist at *surgery*—when performed by a *physician*, *dentist,* or *podiatrist* who assists the operating surgeon in performing covered *surgery* in a *hospital,* or *ambulatory surgical facility*. In addition, benefits will be provided for assist at *surgery* when performed by a Registered Surgical Assistant or an *advanced practice nurse*. Benefits will also be provided for assist at *surgery* performed by a *physician assistant* under the direct supervision of a *physician*, *dentist*, or *podiatrist*.
- Sterilization procedures (even if they are *elective surgery*).

Additional Surgical Opinion

Your coverage includes benefits for an additional surgical opinion following a recommendation for *elective surgery*. Your benefits will be limited to one consultation and related *diagnostic service* by a *physician*. Benefits for an additional surgical opinion consultation and related *diagnostic service* will be covered and is subject to the program *deductible*. If you request, benefits will be provided for an additional consultation when the need for *surgery*, in your opinion, is not resolved by the first arranged consultation.

Medical Care

Benefits are available for *medical care* visits when:

- You are an *inpatient* in a *hospital*, a skilled nursing facility, or *substance abuse treatment facility*;
- You are a patient in a *partial hospitalization treatment program* or *coordinated home care program*; or
- You visit your physician's office, or your physician comes to your home.

Consultations

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

Diabetes Self-Management Training and Education

Benefits will be provided for *outpatient* self-management training, education and medical nutrition therapy. Benefits will be provided if these services are rendered by a *physician* or duly certified, registered or licensed health care professionals with expertise in diabetes management. Benefits for such health care professionals will be provided as described under "Other Covered Services" in this main section. Benefits are also available for regular foot care examinations by a *physician* or *podiatrist*.

Diagnostic Service

Benefits will be provided for those services related to covered *surgery* or *medical care*.

Emergency Accident Care

Treatment must occur as soon as reasonably possible.

Emergency Medical Care

Benefits for *emergency accident or medical care* will be subject to *deductible* and *coinsurance*, if a true emergency.

However, *covered services* received for *emergency accident care* and *emergency medical care* resulting from criminal sexual assault or abuse will be paid at 100% of the *eligible charge* whether or not you have met your program *deductible*. The emergency room *copay* will not apply.

Electroconvulsive Therapy
Allergy Injections and Allergy Testing
Acupuncture in Lieu of Anesthesia Only
Chemotherapy
Marriage and Family Therapy

Occupational Therapy

Benefits will be provided for *occupational therapy* when these services are rendered by a registered occupational therapist under the supervision of a *physician*. This therapy must be furnished under a written plan established by a *physician* and regularly reviewed by the therapist and *physician*. The plan must be established before treatment is begun and must relate to the type, amount, frequency, and duration of therapy and indicate the diagnosis and anticipated goals. There is a combined therapies maximum of 60 visits (in- or out-of-network) per *Plan Year*; subject to clinical review around 20 visits.

Physical Therapy

Benefits will be provided for *physical therapy* when rendered by a registered professional *physical therapist* under the supervision of a *physician*. The therapy must be furnished under a written plan established by a *physician* and regularly reviewed by the therapist and the *physician*. The plan must be established before treatment is begun and must relate to the type, amount, frequency, and duration of therapy and indicate the diagnosis and anticipated goals. There is a combined therapies maximum of 60 visits (in- or out-of-network) per *Plan Year*; subject to clinical review around 20 visits.

Speech Therapy

Benefits will be provided for *speech therapy* when these services are rendered by a licensed *speech therapist* or *speech therapist* certified by the American Speech and Hearing Association. *Inpatient speech therapy* benefits will be provided only if *speech therapy* is not the only reason for admission. There is a combined therapies maximum of 60 visits (in- or out-of-network) per *Plan Year*; subject to clinical review around 20 visits.

Chiropractic and Osteopathic Manipulation

Benefits will be provided for manipulation or adjustment of osseous or articular structures, commonly referred to as chiropractic and osteopathic manipulation, when performed by a person licensed to perform such procedures. Your benefits for chiropractic and osteopathic manipulation will be limited to a maximum of 60 visits per benefit period. However, after 20 visits, medical necessity is required up to a maximum of 60 visits (in- or out-of-network) per *Plan Year*; subject to clinical review around 20 visits.

Cognitive Rehabilitation Coverage

Benefits are payable for cognitive rehabilitation (as a distinct and definable component of the rehabilitation process) which is considered to be medically necessary in the rehabilitation of a patient with traumatic brain *injury* under the following circumstances:

- Services are prescribed by the attending *physician* as part of a written care plan;
- Prescribed services are provided by a qualified licensed professional;
- There is a potential for improvement based on pre-*injury* function; and
- The patient has sufficient cognitive function to understand and participate in the program, as well as adequate language expression and comprehension (i.e., the participant should not have severe aphasia).

Please note: Ongoing services may be considered medically necessary only when there is demonstrated continued objective improvement in function.

Cognitive rehabilitation (as a distinct and definable component of the rehabilitation process) is considered experimental, investigational, and unproven for all other applications, including, but not limited to:

- Stroke;
- Post-encephalitic or post-encephalopathy patients;
- The aging population; and
- Alzheimer's patients.

Radiation Therapy Treatments
Clinical Breast Examinations

Benefits will be provided for clinical breast examinations when performed by a *physician*, *advanced practice nurse*, or a *physician assistant* working under the direct supervision of a *physician*.

Bone Mass Measurement and Osteoporosis

Benefits will be provided for bone mass measurement and the diagnosis and treatment of osteoporosis.

Durable Medical Equipment

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

Amino Acid-Based Elemental Formulas

Benefits will be provided for amino acid-based elemental formulas for the diagnosis and treatment of eosinophilic disorders or short-bowel syndrome, when the prescribing *physician* has issued a written order stating that the amino acid-based elemental formula is medically necessary. If you purchase the formula at a retail pharmacy, you may be required to submit a *claim* for reimbursement to the medical plan.

Outpatient Contraceptive Services

Benefits will be provided for prescription contraceptive devices, injections, implants, and *outpatient* contraceptive services. *Outpatient* contraceptive services means consultations, examinations, procedures and medical services provided on an *outpatient* basis and related to the use of contraceptive methods (including natural family planning) to prevent an unintended pregnancy. Benefits for prescription contraceptive devices and implants will not be subject to a calendar year maximum.

Leg, Back, Arm and Neck Braces
Prosthetic Appliances

Benefits will be provided for *prosthetic devices (appliances)*, special appliances, and surgical implants when they are required to replace all or a part of:

- An organ or tissue of the human body; or
- The function of a non-functioning or malfunctioning organ or tissue. Benefits will also include adjustments, repair, and replacements of covered *prosthetic devices (appliances)*, special appliances, and surgical implants when required because of wear or change in a patient's condition (excluding dental appliances other than intra-oral devices used in connection with the treatment of *temporomandibular joint dysfunction and related disorders*, subject to specific limitations applicable to *temporomandibular joint dysfunction and related disorders*, and replacement of cataract lenses (that are broken or no longer fit) even though a prescription change is not required).

Other Covered Services

The Plan pays benefits for the following other *covered services*.

Blood and Blood Components

Benefits for charges when blood is needed.

Private Duty Nursing Service

Benefits for *private duty nursing service* will be provided to you in your home only when the services are of such a nature that they cannot be provided by non-professional personnel and can only be provided by a licensed health care *provider*. No benefits will be provided when a *nurse* ordinarily resides in your home or is a member of your immediate family. *Private duty nursing* includes teaching and monitoring of complex care skills such as tracheotomy suctioning, medical equipment use and monitoring to home caregivers and is not intended to provide for long-term supportive care. Benefits for *private duty nursing service* will not be provided due to the lack of willing or available non-professional personnel. Your benefits for *private duty nursing service* are limited to a maximum of 70 days per benefit period.

Ambulance Transportation

Benefits will not be provided for long distance trips or for use of an ambulance because it is more convenient than other transportation.

Dental Accident Care

Dental services rendered by a *dentist* or *physician* which are required as the result of an accidental *injury*.

Oxygen and Its Administration
Medical and Surgical Dressings, Supplies, Casts, and Splints
Wigs

Benefits will be provided for wigs (also known as cranial prostheses) when your hair loss is due to *chemotherapy*, radiation therapy, or alopecia (excluding Androgenetic Alopecia), Lupus, and fungal infections.

Expenses Associated With Approved Clinical Trials

Benefits are provided for routine expenses related to a qualified individual's participation in an approved clinical trial for cancer or another life-threatening disease.

Under the Blue Cross Blue Shield National coverage options, benefits are provided for the cost of routine patient care associated with *investigational* cancer treatment if you are a qualified individual participating in a qualified clinical cancer trial, if those services or supplies would otherwise be covered as described in this Summary Plan Description if not provided in connection with a qualified cancer trial program.

Services for Special Conditions

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

Human Organ Transplants

Covered services for transplants must be received from a Blue Distinction Center. Transplant benefits are not covered when services are received from a *provider* other than a Blue Distinction Center. Transplant benefits will be provided only for cornea, kidney, bone marrow, heart valve, muscular-skeletal, parathyroid, heart, lung, heart/lung, liver, pancreas, or pancreas/kidney human organ or tissue transplants. Transplant benefits are available to both the recipient and donor of a covered transplant as follows:

- If both the donor and recipient have coverage, each will have their benefits paid by their own program.
- If you are the recipient of the transplant, and the donor for the transplant has no coverage from any other source, the benefits described will be provided for both you and the donor. In this case, payments made for the donor will be charged against your benefits.
- If you are the donor for the transplant and no coverage is available to you from any other source, the benefits described will be provided for you.

However, no benefits will be provided for the recipient. Benefits will be provided for:

- *Inpatient* and *outpatient covered services* related to the transplant *surgery*.
- The evaluation, preparation, and delivery of the donor organ.
- The removal of the organ from the donor.
- The transportation of the donor organ to the location of the transplant *surgery*. Benefits will be limited to the transportation of the donor organ in the United States or Canada.

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

- Whenever a heart, lung, heart/lung, liver, pancreas, or pancreas/kidney transplant is recommended by your physician, you must contact the *claims administrator* by telephone before your transplant surgery has been scheduled.

- The *claims administrator* will furnish you with the names of facilities that participate in the *claims administrator*-approved Human Organ Transplant Program. In order to obtain the highest level of benefit, you must use one of these facilities.
- If you are the recipient of the transplant, benefits will be provided for transportation and lodging for you and a companion. If the recipient of the transplant is a dependent child under the limiting age, benefits for transportation and lodging will be provided for the transplant recipient and two companions. For benefits to be available, your place of residency must be more than 50 miles from the hospital where the transplant will be performed.

Autism Spectrum Disorder (ASD)

Coverage includes occupational therapy, speech therapy, and physical therapy for covered participants with autism or an ASD.

Bariatric Surgery

Covered services for bariatric *surgery* must be received from a Blue Distinction Center. Bariatric *surgery* is not covered when services are received from a *provider* other than a Blue Distinction Center.

Benefits will be provided for transportation and lodging for you and a companion if your place of residency is more than 50 miles from the Blue Distinction Center where the surgery will be performed.

Cardiac Rehabilitation Services

Benefits will be provided for cardiac rehabilitation services only in *claims administrator*-approved programs. Benefits are available if you have a history of any of the following: acute myocardial infarction, coronary artery bypass graft *surgery*, percutaneous transluminal coronary angioplasty, heart valve *surgery*, heart transplantation, stable angina pectoris, compensated heart failure, or transmyocardial revascularization. Benefits will be limited to a maximum of 36 *outpatient* treatment sessions within a six-month period.

Preventive Care

Benefits will be provided for the following *covered services* and will not be subject to any *deductible*, *coinsurance*, *copay*, or maximum when such services are received from a *participating provider*:

- Evidence-based items or services that have in effect a rating of “A” or “B” in the current recommendations of the United States Preventive Services Task Force (“USPSTF”).
- Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (“CDC”) with respect to the individual involved.
- Evidence-informed *preventive care* and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (“HRSA”) for infants, children, and adolescents.
- With respect to women, such additional *preventive care* and screenings, not described above, as provided for in comprehensive guidelines supported by the HRSA (for example, BRCA Testing, if appropriate).

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

The *preventive care* services described above may change as USPSTF, CDC, and HRSA guidelines are modified.

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

Examples of covered immunizations included are Diphtheria, Haemophilus influenza type b, Hepatitis B, Measles, Mumps, Pertussis, Polio, rubella, Tetanus, Varicella, and other immunization that is required by law for a child(ren).

Allergy injections are not considered immunizations under this benefit provision.

Wellness Care

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

- Routine diagnostic medical procedures.
- Routine X-ray,
- Routine ovarian cancer screening,
- Routine colorectal cancer screening X-ray,
- Routine vision examination (including refraction)—one every 24 consecutive months.
- Routine hearing examination—one every 24 consecutive months.
- Hearing aids for dependent children under age 19 with congenital defects.

Skilled Nursing Facility Care

The following are *covered services* when you receive them in a skilled nursing facility:

- Bed, board and general nursing care.
- Ancillary services (such as drugs and surgical dressings or supplies). No benefits will be provided for admissions to a skilled nursing facility which are for the convenience of the patient or *physician* or because care in the home is not available or the home is unsuitable for such care.
- Benefits for *covered services* rendered in an administrator-approved skilled nursing facility. You are entitled to benefits for 120 days of care in a skilled nursing facility per benefit period.

Ambulatory Surgical Facility

Benefits for all of the *covered services* previously described are available for *outpatient surgery*. In addition, benefits will be provided if these services are rendered by an *ambulatory surgical facility*.

Substance Abuse Rehabilitation Treatment

Benefits for all of the *covered services* described are available for *substance abuse rehabilitation treatment*. In addition, benefits will be provided if these *covered services* are rendered by a *behavioral health provider* in a *substance abuse treatment facility*. *Substance abuse rehabilitation treatment covered services* rendered in a program that does not have a written agreement with the *claims administrator* or in a non-administrator-approved *provider* facility will be paid at the non-*claims administrator*-approved *provider* facility payment level.

Mental Illness Services

Benefits for all of the *covered services* described are available for the diagnosis and/or treatment of *mental illness* disorders. *Medical care* for the treatment of a *mental illness* is eligible when rendered by a *behavioral health provider* working within the scope of his or her license.

Maternity Service

Your benefits for *maternity service* are the same as your benefits for any other condition. Benefits will also be provided for *covered services* rendered by a *certified nurse-midwife*.

Benefits will be paid for *covered services* received in connection with both *normal pregnancy* and complications of pregnancy. As part of your maternity benefits certain services rendered to your newborn infant are also covered, even if you have Individual Coverage. These *covered services* are: a) the routine *inpatient hospital* nursery charges, b) one routine *inpatient* examination, and c) one *inpatient* hearing screening as long as this examination is rendered by a *physician* other than the *physician* who delivered the child or administered anesthesia during delivery. (If the newborn child needs treatment for an *illness* or *injury*, benefits will be available for that care only if you have Employee and Family coverage.

Benefits will be provided for any *hospital* length of stay in connection with childbirth for the mother or newborn child for no less than 48 hours following a normal vaginal delivery, or no less than 96 hours following a cesarean section. Your *provider* will not be required to obtain authorization from the *claims administrator* for prescribing a length of stay less than 48 hours (or 96 hours).

Your coverage also includes benefits for the treatment of gestational diabetes and *elective* abortions if legal where performed.

Infertility Treatment

Benefits will be provided the same as your benefits for any other condition for *covered services* rendered in connection with the diagnosis and/or treatment of underlying cause of *infertility* in conjunction with conception through normal intercourse or the inability to sustain a successful pregnancy.

Under the Blue Cross Blue Shield National coverage options, "*infertility*" means the inability to conceive a child after one year of unprotected sexual intercourse or the inability to sustain a successful pregnancy. The one-year requirement will be waived if your *physician* determines a medical condition exists that makes conception impossible through unprotected sexual intercourse including, but not limited to, congenital absence of the uterus or ovaries, absence of the uterus or ovaries due to surgical removal due to a medical condition, or involuntary sterilization due to *chemotherapy* or radiation treatments; or, efforts to conceive as a result of one year of medically based and supervised methods of conception, including artificial insemination, have failed and are not likely to lead to a successful pregnancy. "Unprotected sexual intercourse" means sexual union between a male and female without the use of any process, device, or method that prevents conception including, but not limited to, oral contraceptives, chemicals, physical or barrier contraceptives, natural abstinence, or voluntary permanent surgical procedures and includes appropriate measures to ensure the health and safety of sexual partners.

Temporomandibular Joint Dysfunction and Related Disorders

Benefits for all of the *covered services* previously described are available for the diagnosis and treatment of *temporomandibular joint dysfunction and related disorders*.

Mastectomy-Related Services

Mastectomy-related *covered services* include, but are not limited to:

- Reconstruction of the breast on which the mastectomy has been performed;
- *Surgery* and reconstruction of the other breast to produce a symmetrical appearance;
- *Inpatient* care following a mastectomy for the length of time determined by your attending *physician* to be medically necessary and in accordance with protocols and guidelines based on sound scientific evidence and patient evaluation and a follow-up *physician* office visit or in-home *nurse* visit within 48 hours after discharge; and
- Prostheses and physical complications of all stages of the mastectomy including, but not limited to, lymphedemas.

Hospice Care Program

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

The following services are covered under the *hospice care program*:

- Coordinated home care;
- Medical supplies and dressings;
- Medication;

- Nursing services—*skilled* and non-*skilled*;
- *Occupational therapy*;
- Pain management services;
- *Physical therapy*;
- *Physician* visits;
- Social and spiritual services; and
- *Respite care service*.

Benefits for Medicare-Eligible Covered Persons

This section describes the benefits which will be provided for *Medicare*-eligible covered persons who are not affected by *MSP* laws, unless otherwise specified (see ‘‘Medicare-Eligible Covered Persons’’ under “Your Dependents” in the “Eligibility” main section).

The benefits and provisions described apply to you, however, in determining the benefits to be paid for your *covered services*, consideration is given to the benefits available under *Medicare*.

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

- Determine what the payment for a *covered service* would be following the payment provisions of this coverage; and
- Deduct from this resulting amount the amount paid or payable by *Medicare*. (If you are eligible for *Medicare*, the amount that is available from *Medicare* will be deducted whether or not you have enrolled and/or received payment from *Medicare*.) The difference, if any, is the amount that will be paid under the Plan.

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

The Life Resources Program

The WKUS Life Resources Program (LRP) offers you and your dependents a highly professional and confidential source of assistance for *substance abuse*, emotional, or personal problems. Through the LRP, you can receive confidential assessments, professional counseling, education, and referrals. And, if the problem can't be resolved through the LRP's short-term counseling services, the program attempts to coordinate treatment with this Plan. See “The Life Resources Program (LRP)” main section for more details.

What the Plan Doesn't Cover

Overview

The Plan doesn't cover all types of medical expenses, even if prescribed, ordered, recommended, approved, or viewed as medically necessary by your *physician*. Hospitalization or other health care services and supplies must be medically necessary and if the *claims administrator* deems them not to be the cost of the hospitalization, services or supplies will not be covered.

The *claims administrator* will make the decision whether hospitalization or other health care services or supplies were not medically necessary and therefore not eligible for payment under the terms of your health care plan. In most instances this decision is made by the *claims administrator* after you have been hospitalized or have received other health care services or supplies and after a *claim* for payment has been submitted.

This section includes important information regarding excluded expenses. Charges made for the following aren't covered, except to the extent listed under the “What the Plan Covers” main section.

- Any charges in excess of the benefit, dollar, day, visit, or supply limits stated in this document.
- Costs for services resulting from the commission of, or attempt to commit, a felony by the covered person.
- Court-ordered services, including those required as a condition of parole or release.
- Miscellaneous charges for services or supplies, including charges the recipient has no legal obligation to pay, or the charges wouldn't be made if the recipient didn't have coverage (to the extent exclusion is permitted by law), including:
    - Care for conditions related to current or previous military service; and
    - Care while in the custody of a governmental authority.
- Non-medically necessary services.
- Services rendered before the effective date or after the termination of coverage, unless coverage is continued as described under the “How Long Coverage Continues” main section.
- Any *illness* or *injury* related to employment or self-employment, including any injuries that arise out of (or in the course of) any work for pay or profit, unless no other source of coverage or reimbursement is available to you for the services or supplies. Sources of coverage or reimbursement may include your employer, Workers' Compensation, or an occupational *illness* or similar program under local, state, or federal law. A source of coverage or reimbursement will be considered available to you even if you waived your right to payment from that source. If you're also covered under a Workers' Compensation Law or similar law and submit proof that you're not covered for a particular *illness* or *injury* under such law, that *illness* or *injury* will be considered “non-occupational” regardless of cause.

Excluded Expenses Under Blue Cross Blue Shield

The Plan doesn't pay benefits for the following.

Hospitalization (and related services and supplies)

No benefits will be provided for services which are not, in the reasonable judgment of the *claims administrator*, medically necessary. Medically necessary means that a specific medical, health care or *hospital* service is required, in the reasonable medical judgment of the *claims administrator*, for the treatment or management of a medical symptom or condition and that the service or care provided is the most efficient and economical service which can safely be provided.

Hospitalization is not medically necessary when, in the reasonable medical judgment of the *claims administrator*, the medical services provided did not require an acute *hospital inpatient* (overnight) setting, but could have been provided in a *physician's* office, the *outpatient* department of a *hospital* or some other setting without adversely affecting the patient's condition.

Examples of hospitalization and other health care services and supplies that are not covered under the Plan:

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

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

Human Organ Transplants

Expenses for the following are not covered under the Plan:

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

Infertility

Expenses for the following are not covered under the Plan:

- Services or supplies rendered to a surrogate, except that costs for procedures to obtain eggs, sperm, or embryos from you will be covered if you choose to use a surrogate.
- Selected termination of an embryo; however, termination will be covered where the mother's life would be in danger if all embryos were carried to full term.
- Expenses incurred for cryo-preservation or storage of sperm, eggs, or embryos, except for those procedures which use a cryo-preserved substance.
- Non-medical costs of an egg or sperm donor.
- Travel costs for travel within 100 miles of your home or travel costs not medically necessary or required by the *claims administrator*.
- *Infertility* treatments which are deemed investigational, in writing, by the American Society for Reproductive Medicine or the American College of Obstetricians or Gynecologists.
- *Infertility* treatment rendered to your dependents under age 18.

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

Hospice Care Program

Expenses for the following are not covered under the Plan:

- *Durable medical equipment.*
- Home delivered meals.
- Homemaker services.
- Traditional medical services provided for the direct care of the *terminal illness*, disease. or condition.
- Funeral arrangements.
- Financial or legal counseling (including estate planning and the drafting of a will).
- Transportation, including, but not limited to, *ambulance transportation*.

There may be clinical situations when short episodes of traditional care would be appropriate even when the patient remains in the hospice setting. While these traditional services are not eligible under the Hospice Care provisions of the Plan, they may be *covered services* under other sections of this SPD.

Other Services and Supplies

Expenses for the following are not covered under the Plan:

- Services or supplies that are not specifically mentioned in this SPD.
- Services of a resident physician or intern rendered in that capacity.
- Services or supplies for any *illness* or *injury* arising out of or in the course of employment for which benefits are available under any Workers' Compensation Law or other similar laws whether or not you make a claim for such compensation or receive such benefits. However, this exclusion shall not apply if you are a corporate officer of any domestic or foreign corporation and are employed by the corporation and elect to withdraw yourself from the operation of the Illinois Workers' Compensation Act according to the provisions of the Act.
- Services or supplies that are furnished to you by the local, state, or federal government and for any services or supplies to the extent payment or benefits are provided or available from the local, state, or federal government (for example, Medicare) whether or not that payment or benefits are received, except however, this exclusion shall not be applicable to medical assistance benefits under Article V or VI of the Illinois Public Aid Code (305 ILCS 5/5-1 et seq. or 5/6-1 et seq.) or similar Legislation of any state, benefits provided in compliance with the Tax Equity and Fiscal Responsibility Act or as otherwise provided by law.
- Services and supplies for any *illness* or *injury* occurring on or after your coverage date as a result of war or an act of war.
- Services or supplies that do not meet accepted standards of medical and/or dental practice.
- *Investigational services and supplies* and all related services and supplies, except as may be described in this SPD for the cost of routine patient care associated with *investigational* cancer treatment, if those services or supplies would otherwise be covered under the Plan if not provided in connection with an approved clinical trial program for cancer and other life-threatening diseases.
- *Custodial care service*.
- Long Term Care Service.
- *Respite care service*, except as specifically mentioned under the "What Is Covered" main section.
- *Inpatient private duty nursing service*.
- *Convalescent care service*.
- Routine physical examinations, unless otherwise specified in this SPD.
- Services or supplies received during an *inpatient* stay when the stay is primarily related to behavioral, social maladjustment, lack of discipline, or other antisocial actions which are not specifically the result of *mental illness*. This does not include services or supplies provided for the treatment of an *injury* resulting from an act of domestic violence or a medical condition (including both physical and mental health conditions).
- *Cosmetic surgery*, plastic *surgery*, *reconstructive surgery*, and other related services and supplies designed to improve, alter, or enhance appearance (regardless of whether the *surgery* is performed for emotional or psychological reasons). Exception for the correction of congenital deformities or for conditions resulting from accidental *injuries*, scars, tumors, or diseases.
- Services or supplies for which you are not required to make payment or would have no legal obligation to pay if you did not have this or similar coverage.
- Charges for failure to keep a scheduled visit or charges for completion of a claim form.
- Personal hygiene, comfort, or convenience items commonly used for other than medical purposes, such as air conditioners, humidifiers, physical fitness equipment, televisions, and telephones.

- Special braces, splints, specialized equipment, appliances, ambulatory apparatus, battery implants, except as specifically mentioned in this SPD.
- Blood derivatives which are not classified as drugs in the official formularies.
- Eyeglasses, contact lenses, or cataract lenses and the examination for prescribing or fitting of glasses or contact lenses or for determining the refractive state of the eye, except as specifically mentioned in this SPD.
- Treatment of flat foot conditions and the prescription of supportive devices for such conditions and the treatment of subluxations of the foot.
- Routine foot care, except for persons diagnosed with diabetes.
- Immunizations, unless otherwise specified in this SPD.
- *Maintenance occupational therapy, maintenance physical therapy*, and *maintenance speech therapy*, except as specifically mentioned in this SPD.
- *Maintenance care*.
- Hearing aids or examinations for the prescription or fitting of hearing aids, unless otherwise specified in this SPD.
- Services and supplies to the extent benefits are duplicated because the spouse, parent, and/or child are covered separately under this Plan.
- *Diagnostic service* as part of routine physical examinations or checkups, premarital examinations, determination of the refractive errors of the eyes, auditory problems, surveys, case finding, research studies, screening, or similar procedures and studies, or tests which are *investigational*, unless otherwise specified in this SPD.
- Procurement or use of *prosthetic devices (appliances)*, special appliances, and surgical implants which are for *cosmetic* purposes, the comfort and convenience of the patient, or unrelated to the treatment of a disease or *injury*.
- Short-term rehabilitation services that:
    - Are covered to any extent under any other part of this Plan;
    - Are covered in whole or in part under any other group plan sponsored by the *Company*;
    - You receive while confined in a *hospital* or other facility or not performed by a *physician* or under his or her direct supervision;
    - Are provided by a *physical,* occupational*, or speech therapist* who lives in your home or who's part of your or your spouse's family or are educational in nature, including special education and sign language lessons, if your ability to speak has been lost or impaired; and
    - Are not in accordance with a specific treatment plan detailing the treatment to be provided and the frequency and duration of the treatment; and requiring ongoing reviews and is renewed only if therapy is still necessary.
- Services and supplies provided in connection with treatment or care that's not covered under the Plan.
- *Speech therapy* to treat delays in speech development, except as specifically provided under the “What the Plan Covers” main section. For example, the Plan doesn't cover therapy when it's used to improve speech skills that haven't fully developed.
- Spinal disorder therapy, including care related to:
    - The detection and correction by manual or mechanical means of structural imbalance, distortion, or dislocation in the human body; and
    - Physical treatment of any condition that's caused by or related to biomechanical or nerve conduction spine disorders (including manipulation of the spine treatment, except as specifically provided under the “What the Plan Covers” main section).

- Strength and performance services, devices, and supplies designed to enhance strength, physical condition, endurance, or physical performance, including:
    - Exercise equipment, memberships in health or fitness clubs, training, advice, or coaching, drugs or preparations to enhance strength, performance, or endurance; and
    - Treatments, services, and supplies to treat *illnesses*, *injuries*, or disabilities related to the use of performance-enhancing drugs or preparations.
- Therapies to treat delays in development (unless the delay results from an acute *illness* or *injury*) or congenital defects amenable to surgical repair (such as cleft lip/palate). Examples of exclusions include pervasive developmental disorders such as Down syndrome, and cerebral palsy, which are considered developmental and/or chronic in nature.
- Services with a diagnosis of autism (except for physical, speech, and occupational therapies, up to established clinical benchmarks).
- The following therapies, tests, treatments, or procedures:
    - Aromatherapy, bio-feedback and bioenergetic therapy, carbon dioxide therapy, chelation therapy (except for heavy metal poisoning), computer-aided tomography (CAT) scanning of the entire body, educational therapy, gastric irrigation, hair analysis, hyperbaric therapy, except for the treatment of decompression or to promote healing of wounds, hypnosis and hypnotherapy, except when performed by a *physician* as a form of anesthesia in connection with covered *surgery*; Lovaas therapy, massage therapy, megavitamin therapy, primal therapy, psychodrama, purging, recreational therapy, rolfing, sensory or auditory integration therapy, sleep therapy, and thermograms and thermography.
- Education, special education, or job training whether or not given in a facility that also provides medical or psychiatric treatment.
- Acupuncture therapy (except when acupuncture is performed by a *physician* as a form of anesthesia in connection with a covered *surgery*).
- Services for or in connection with *speech therapy*. This exclusion doesn't apply when therapy is expected to restore speech to a person who has lost existing speech functions (i.e., the ability to express thoughts, speak words, and form sentences) as a result of an *illness* or *injury*.
- Wigs (also referred to as cranial prostheses), unless otherwise specified in this SPD.
- Services and supplies rendered or provided for human organ or tissue transplants other than those specifically named in this SPD.
- Reversals of sterilization.
- Completely and partially bony impacted wisdom teeth.

The Managed Care Program

About the Managed Care Program

The Managed Care Program is designed to help determine the best *course of treatment* for your situation that will maximize your Plan benefits by managing health care costs for you and Wolters Kluwer. Registered graduate *nurses* and other trained staff members with clinical backgrounds staff the Program in conjunction with consultant *physicians*.

You can reach the Managed Care Program by calling Blue Cross Blue Shield Customer Service at **1-877-238-5944**. Your ID card also has a toll-free number to call before certain procedures. If you receive *network care*, you or your *provider* needs to call this number to meet certain preauthorization (prior authorization) requirements. If you don't, or you don't comply with the Program's determinations, financial penalties apply. Here's some important information regarding the Program, the Program's requirements, and its provisions.

Preauthorization Requirements

Preauthorization (preadmission review) is required for certain services. These services include, but aren't limited to, *inpatient hospital* admissions, emergency admissions, alternatives to *inpatient hospital* care (including skilled nursing, *private duty*, *hospice*, and home health care), *private duty nursing*, use of *durable medical equipment* (such as wheelchairs), transplants, select *outpatient* services, pregnancy/maternity admissions, and *inpatient* behavioral health and *substance abuse* treatments. Preauthorization is designed to assess the *medical necessity* and length of such admissions and treatments.

When preauthorization is required it is your responsibility that you, your family, or the *provider* of the services complies with these guidelines. Failure to obtain preauthorization will result in additional steps, benefit reductions, and a $250 penalty. Please contact Blue Cross Blue Shield Customer Service or your *provider* to discuss the necessity of preauthorization for your specific care.

Even if you follow the preauthorization requirements, this doesn't guarantee that the Plan will pay benefits. Benefit availability is subject to eligibility and other terms, conditions, limitations, and exclusions of the Plan.

Preauthorization review provisions of the Managed Care Program do not apply to a covered family member who is *Medicare*-eligible and has secondary coverage under this Plan.

Inpatient Hospital (and Residential Treatment Facility) Admissions

If your *physician* recommends a non-emergency or non-maternity *inpatient hospital* admission, for any reason, you (or someone on your behalf) must call Blue Cross Blue Shield Customer Service to preauthorize care. **The call must be made at least one business day before your non-urgent *hospital* admission. Otherwise, the Plan doesn't pay the maximum level of benefits for *eligible expenses.***

Hospital (and Residential Treatment Facility) Expenses Incurred During the Confinement

If certification is requested and denied, the Plan doesn't pay benefits for *room and board hospital* expenses. The Plan does, however, pay benefits for all other *hospital* expenses at the Plan's usual benefit payment percentage.

If certification isn't requested and it's determined that the *confinement* (or any day of such *confinement*) **isn't necessary**, the Plan doesn't pay benefits for *room and board hospital* expenses. All other *hospital* expenses, up to the excluded amount, also are considered excluded expenses. The Plan does, however, pay benefits for such expenses in excess of the excluded amount at the Plan's usual benefit payment percentage. If it's determined that the *confinement* (or any day of such *confinement*) **is necessary**, the Plan doesn't pay benefits for *room and board hospital* expenses, up to the excluded amount. The Plan does, however, pay benefits for all other *hospital* expenses at the Plan's usual benefit payment percentage.

Other Covered Expenses

The Plan pays benefits at the usual benefit payment percentage. Regardless of whether a day of *confinement* is certified, the Plan doesn't pay benefits for any expense incurred on any day of full-time *inpatient confinement* if the expense is normally excluded from benefits under any other terms of the Plan. However, if certification is given for a day of *confinement*, the excluded service or supply (because it's not necessary) won't be applied to expenses for *hospital room and board*.

How to Obtain Certification

If your admission is a non-urgent admission, you (or someone on your behalf) must call the number on your ID card and obtain certification. The call must be made at least one business day before the date you're scheduled to be confined as a full-time *inpatient*.

If your admission is an urgent admission, you (or someone on your behalf) must call the number on your ID card and obtain certification within 48 hours. The call must be made before the start of the full-time *inpatient confinement*. If it's not possible for your *provider* to request certification within the time period required, certification must be obtained as soon as reasonably possible. If a *confinement* begins on a Friday or Saturday, the 48-hour requirement is extended to 72 hours.

If, in the opinion of your *physician*, it's necessary that you be confined for a longer period of time than the days already certified, you, your *physician*, or the *hospital* may request that more days be certified, by requesting a length of stay review. To do so, call the number on your ID card.

When you call, a consulting registered *nurse* collects information from you and/or your *physician* and precertifies the necessity for your admission as well as the number of days for which the Plan will pay benefits. (In the case of a *surgery*, preauthorization can help determine whether or not you should obtain a second surgical opinion.) If, as a result of the preauthorization process, your proposed *hospital* admission or service is determined not to be medically necessary, your care is referred to the *claims administrator's physician* for review. If the *physician* concurs that the proposed admission or service isn't medically necessary, the Plan may deny benefits for some days, services, or the entire hospitalization.

Alternatives to Inpatient Hospital Care (Skilled Nursing, Private Duty Nursing, Coordinated Home Health, and Hospice Care)

In the event that you receive alternative *inpatient hospital* care, you or your *provider* must preauthorize care with Blue Cross Blue Shield Customer Service to receive the maximum level of Plan benefits. **The call must be made one business day before the admission**.

Covered Medical Expenses

You may incur a covered medical expense while you're confined in a skilled nursing or *hospice facility*. Or, you may receive a *covered service,* or a supply related to skilled nursing care, home health care, or *hospice care* while you're not confined as an *inpatient*. If this is the case, and it's **not** certified that such *confinement* (or any day of *confinement*) is necessary, such service or supply (either specifically or as part of a planned program of care) is necessary, or the *confinement* or service or supply hasn't been ordered or prescribed by your *physician* or a preferred *provider*, the Plan pays benefits as follows.

- **Skilled Nursing and Hospice Care Expenses (Incurred While Confined in a Skilled Nursing or Hospice Facility):** If certification is requested and denied, the Plan doesn't pay benefits for skilled nursing or *hospice care facility* expenses incurred for *room and board*. The Plan does, however, pay benefits for all other skilled nursing or *hospice care facility* expenses incurred during the *confinement* at the Plan's usual benefit payment percentage.

  If certification isn't requested and it's determined that the *confinement* (or any day of such *confinement*) **isn't necessary**, the Plan doesn't pay benefits for skilled nursing or *hospice care facility* expenses incurred for *room and board*. All other skilled nursing or *hospice care facility* expenses incurred during the *confinement*, up to the excluded amount, also are considered excluded expenses. The Plan does, however, pay benefits for all other such expenses in excess of the excluded amount at the Plan's usual benefit payment percentage. If it's determined that the *confinement* (or any day of such *confinement*) **is necessary**, the Plan doesn't pay benefits for skilled nursing or *hospice care facility* expenses incurred during the *confinement*, up to the excluded amount. The Plan does, however, pay benefits for all other such expenses incurred during the *confinement* at the Plan's usual benefit payment percentage. Regarding all other covered medical expenses incurred during the *confinement*, the Plan pays benefits at the usual benefit payment percentage.
- ***Covered services* or Supplies Either Stated or Part of a Planned Program of Skilled Nursing Care, Coordinated Home Health Care, or Hospice Care (Incurred While Not Confined as an Inpatient):** If certification for a service or supply is requested and denied, or if certification isn't requested and the service or supply isn't necessary, the Plan doesn't pay benefits for the denied or unnecessary service or supply.

  If certification isn't requested for a service or supply and it's determined that the service or supply is necessary, the Plan doesn't pay benefits for the service or supply, up to the excluded amount. The Plan does, however, pay benefits for all other covered expenses incurred for the service or supply at the Plan's usual benefit payment percentage. Regardless of whether a day of *confinement* or a service or supply is *certified*, the Plan doesn't pay benefits for any expense if the expense is normally excluded from benefits under any other terms of the Plan. However, if certification is given for a day of *confinement*, the excluded service or supply (because it's not necessary) won't be applied to expenses for convalescent or *hospice care facility* expenses incurred for room and board. To the extent that such service or supply is certified for home health care, hospice care, or skilled nursing care, the excluded service or supply (because it's not necessary) won't be applied to such service or supply.

How to Obtain Certification

You must call the number on your ID card and obtain certification. The call must be made before an expense is incurred. If, in the opinion of your *physician*, it's necessary that you receive more days of *confinement*, services, or supplies beyond those that are already certified, you must call to obtain certification for the additional days of *confinement*, services, or supplies.

You receive prompt written notification of the certified days of *confinement*, services, or supplies. **Please note:** If your *hospice care* service or supply is certified and you later require a *hospital confinement* either for pain control or acute symptom management, the Plan waives the certification requirements for any such day of *hospital confinement*.

Emergency/Urgent Care Admissions

In the event of an urgent care admission, you (or someone on your behalf) must call Blue Cross Blue Shield Customer Service to certify care. **The call must be made no later than two business days from the start of the *confinement* that requires *urgent care***. If it's not possible for you or your *physician* to certify care within this time period, certification must be met within 48 hours of the admission. Otherwise, the Plan doesn't pay the maximum level of benefits for *eligible expenses*.

Pregnancy/Maternity Admissions

In the event of a maternity admission, you or your *provider* must preauthorize the pregnancy with Blue Cross Blue Shield Customer Service to receive the maximum level of Plan benefits. **The call must be made no later than two business days of admission**.

Length of Stay Review

Once the preauthorization process is complete, you and your *provider* or *hospital* receives a confirmation letter. The letter:

- Confirms that you (or someone on your behalf) called Blue Cross Blue Shield beforehand; and
- Assigns an approved length of stay or service to your care.

If your length of stay or service requires an extension, the extension is based solely on whether Blue Cross Blue Shield Customer Service considers continued *inpatient* care or other health care services to be medically necessary. If an extension isn't considered medically necessary, the *claims administrator* won't approve the extended length of stay/services and will refer the case to its *physician* for review.

Benefit availability is subject to eligibility and other terms, conditions, limitations, and exclusions of the Plan.

Case Management

Case Management assists you with coordination of complex care services so that you receive appropriate care in the most effective setting possible (at home, as an *outpatient*, or as an *inpatient* in a *hospital* or a specialized facility as an alternative to *inpatient hospital* care).

If you need Case Management services, a Case Management professional works closely with you, your family, and your attending *physician* to determine appropriate treatment options that best meet your needs. At the same time, Case Management works to manage health care costs. Your Case Manager coordinates your treatment program and arranges for all necessary resources. He or she also is available to answer any questions you might have and can provide ongoing support for your family.

Case Managers are generally R.N.s and other credentialed health care professionals. Each is trained in a clinical specialty area, such as trauma, high-risk pregnancy and neonates, oncology, mental health, rehabilitation, or general medicine and *surgery*. A Case Manager trained in the appropriate specialty area is then assigned to you or your dependent. *Physician* advisors then support the Case Manager by offering guidance on up-to-date treatment programs and medical technology.

Even though a Case Manager may recommend an *alternate treatment* program and coordinate needed resources, your attending *physician* remains responsible for your *medical care*.

Here's how Case Management works:

- You, your dependent, or your attending *physician* requests Case Management services by calling Blue Cross Blue Shield Customer Service (see your ID card for the toll-free number). Please call during normal business hours (Monday through Friday).

- Your case is assessed to determine whether or not Case Management is appropriate.

- A Case Manager then contacts you or your dependent and explains in detail how the Case Management process will work for your specific situation.

- After an initial assessment, the Case Manager works with you, your family, and your *physician* to determine your needs and to identify what *alternate treatment* programs may be available. For example, in-home *medical care* in lieu of an extended *hospital* stay may be a more appropriate *course of treatment* given your condition. If you don't follow the *alternate treatment* program, you're not penalized.

- The Case Manager arranges for *alternate treatment* services and supplies as needed. For example, your *alternate treatment* may require nursing services or a *hospital* bed and other *durable medical equipment* for use in your home.

- The Case Manager also acts as a liaison between the *claims administrator*, you, your family, and your *physician* (as needed). For example, your Case Manager can help you better understand a complex medical diagnosis or treatment plan.

- Once your *alternate treatment* program is in place, your Case Manager continues to manage your case to ensure your program remains appropriate for your needs.

Participants are expected to take advantage of Case Management services. Case Managers offer quality, cost-effective treatment alternatives, and assist you in obtaining necessary medical resources and ongoing family support in a time of need.

If You Fail to Meet Preauthorization Requirements

The final decision regarding your *course of treatment* is your responsibility. The Managed Care Program doesn't interfere with your relationship with any *provider*. However, the *claims administrator* uses The Managed Care Program to help you determine the *course of treatment* that will maximize your Plan benefits as described in this SPD. At the same time, the Managed Care Program manages health care costs.

You (or someone on your behalf) can reach the Managed Care Program by calling Blue Cross Blue Shield at **1-877-238-5944**. If you fail to meet preauthorization requirements, you're responsible for the first $250 of *hospital* or facility charges for each admission. This is in addition to your *deductible* and *coinsurance* requirements. This penalty amount isn't eligible for later consideration as an unreimbursed Plan expense, nor can it be applied to your annual *deductible* or out-of-pocket maximum.

Appealing the Managed Care Program's Decisions

A formal process is in place should you not agree with the Managed Care Program's decision. If you or your *physician* disagree with the determination of the *claims administrator* prior to or while receiving services, you may appeal that decision. You should call the *claims administrator's* customer service number on your identification card. Your *physician* should use the contact information in the notification letter.

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

Medical Director
Health Care Service Corporation
P. O. Box A3957
Chicago, Illinois 60601

See the “Filing an ERISA Claim or Appeal” main section for details.

Blue Care Connection Programs

The Plan also offers these managed care programs to help you lead the healthiest life possible and to help you and Wolters Kluwer manage health care costs. Access to these programs is easy and confidential.

Blue Cross Blue Shield 24/7 Nurseline

This 24-hour, seven-day-a-week *nurse* phone line enables you to:

- Talk directly to a registered *nurse* for answers to your health-related questions.
- Learn about more than 1,000 health and wellness topics over the phone using the audio library system in English (with more than 600 topics in Spanish).

To reach the Blue Cross Blue Shield Informed Health Line, call the toll-free number on the back of your ID card. You also can easily transfer to a registered *nurse* at any time during your call.

Special Beginnings Maternity Program

You can take advantage of the Special Beginnings maternity program during pregnancy and once your baby is born.

By participating in this program, you receive materials on prenatal care, labor and delivery, newborn care, and more. You can even participate in the program's pregnancy risk survey to find out if any issues or risk factors exist that could potentially impact your pregnancy. Through this program, you receive educational materials and support during pregnancy until six weeks after delivery.

Condition Management

The Blue Cross Blue Shield Blue Care Advisors offer support for certain health challenges and chronic conditions like asthma, COPD, coronary heart failure, coronary artery disease, and diabetes. Registered *nurses* and other health care professionals provide education and coaching to help you more easily manage your condition or make lifestyle changes.

The Mental Health Unit

About the Mental Health Unit

The *claims administrator's mental health unit* has been established to perform preadmission review and length of stay review for your *inpatient hospital* services for the treatment of *mental illness* and *substance abuse*. The *mental health unit* is staffed primarily by *physicians*, *psychologists*, and registered *nurses*.

Failure to contact the *mental health unit* or to comply with the determinations of the *mental health unit* may result in a reduction of benefits. The *mental health unit* may be reached 24 hours a day, seven days a week at the toll-free telephone number **1-800-851-7498**. Please read the provisions below very carefully.

It is your responsibility to ensure *preauthorization* requirements are satisfied. You (or someone on your behalf) are responsible for satisfying *preauthorization* requirements. This means that you must ensure that you, your family member, your *behavioral health provider* or *provider* of services must comply with the guidelines below. Failure to *preauthorize* services will require additional steps and/or benefit reductions as described in the “Failure to Preauthorize or Notify” section below.

Preauthorization Requirements

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

- **Inpatient Hospital Preauthorization Review.** In order to receive maximum benefits under this Plan, you must *preauthorize* your non-emergency *inpatient hospital* admission for the treatment of *mental illness* or *substance abuse* by calling the *mental health unit*. This call must be made at least one day prior to the *inpatient hospital* admission.
- **Emergency Mental Illness or Substance Abuse Admission Review.** In order to receive maximum benefits under this Plan, you or someone who calls on your behalf must notify the *mental health unit* **no later than two business days or as soon as reasonably possible after the admission** for the treatment of *mental illness* or *substance abuse* has occurred. If the call is made any later than the specified time period, you will not be eligible for maximum benefits.
- **Partial Hospitalization Treatment Program Preauthorization Review.** In order to receive maximum benefits under this Plan, you must preauthorize your treatment of mental illness or substance abuse rehabilitation treatment by calling the mental health unit. This call must be made at least one day prior to the scheduling of the partial hospitalization treatment program. The mental health unit will obtain information regarding the service(s) and may discuss proposed treatment with your behavioral health provider. If an inpatient emergency mental illness or substance abuse admission occurs after a service(s), in order to receive maximum benefits under this Health Care Plan, an additional call must be made to the mental health unit for an emergency mental illness or substance abuse admission review.

Length of Stay/Service Review

Upon completion of the *preauthorization or emergency mental illness or substance abuse review*, the *mental health unit* will send you a letter confirming that you or your representative called the *mental health unit*. A letter assigning a length of service or length of stay will be sent to your *behavioral health provider* and/or the *hospital*. An extension of the length of stay/service will be based solely on whether continued *inpatient* care or other health care service is medically necessary as determined by the *mental health unit*. In the event that the extension is determined not to be medically necessary, the length of stay/service will not be extended, and the case will be referred to a *mental health unit physician* for review.

Medically Necessary Determination

The decision that *inpatient hospital* admission or other health care services or supplies are not medically necessary, as such term is defined in this SPD, will be determined by the *mental health unit*. If the *mental health unit physician* concurs that the *inpatient hospital* admission, *outpatient* service, or other health care service or supply does not meet the criteria for medically necessary care, some days, services, or the entire hospitalization will be denied. Your *behavioral health provider* and in the case of an *inpatient hospital* admissions, the *hospital* will be advised by telephone of this determinations, with a follow-up notification letter sent to you, your *behavioral health provider* and the *hospital*, and will specify the dates, services, or supplies that are not considered medically necessary. The *mental health unit* will issue these notification letters promptly. However, in some instances, these letters will not be received prior to your scheduled date of admission or service. For further details regarding medically necessary care and other exclusions described in this SPD, see the “What the Plan Doesn’t Cover” main section.

The *mental health unit* does not determine your *course of treatment* or whether you receive particular health care services. The decision regarding the *course of treatment* and receipt of particular health care services is a matter entirely between you and your *behavioral health provider*. The *mental health unit’s* determination of medically necessary care is limited to merely whether a proposed admission, continued hospitalization, or other health care service is medically necessary under the Plan.

In the event that the *mental health unit* determines that all or any portion of an *inpatient hospital* admission or other health care service or supply is not medically necessary, the *claims administrator* will not be responsible for any related *hospital* or other health care service or supply charge incurred.

Remember that the Plan does not cover the cost of hospitalization or any health care services and supplies that are not medically necessary. The fact that your *behavioral health provider* or another health care *provider* may prescribe, order, recommend, or approve an *inpatient hospital* admission or other health care service, or supply does not of itself make such hospitalization, service, or supply medically necessary. Even if your *behavioral health provider* prescribes, orders, recommends, approves, or views hospitalization or other health care services or supplies as medically necessary, the *claims administrator* will not pay for the hospitalization, services, or supplies if the *mental health unit physician* decides they were not medically necessary.

Mental Health Unit Procedure

When you contact the *mental health unit* to *preauthorize* your *inpatient hospital* admission and/or other service/supply, provide notification of your *emergency mental illness or substance abuse admission*, or request a length of stay/service review you should be prepared to provide the following information:

- The name of the attending and/or admitting *behavioral health provider*;
- The name of the *hospital* or facility where the admission and/or service has been scheduled, when applicable;
- The scheduled admission and/or service date; and
- A preliminary diagnosis or reason for the admission and/or service.

When you contact the *mental health unit* to *preauthorize* your *inpatient hospital* admission and/or other service/supply, provide notification of your *emergency mental illness or substance abuse admission*, or request a length of stay/service review, the *mental health unit*:

- Will review the medical information provided and follow-up with the *behavioral health provider*;
- Upon request, will advise you of participating *providers* in the area who may be able to provide the admission and/or services that are the subject of the *preauthorization review*;
- May determine that the admission and/or services to be rendered are not medically necessary.

Appeal Procedure
Expedited Appeal

If you or your *behavioral health provider* disagrees with the determinations of the *mental health unit* prior to or while receiving services, you or the *behavioral health provider* may appeal that determination by contacting the *mental health unit* and requesting an expedited appeal. The *mental health unit physician* will review your case and determine whether the service was medically necessary. You and/or your *behavioral health provider* will be notified of the *mental health unit physician*'*s* determination within 24 hours or no later than the last authorized day. If you or your *behavioral health provider* still disagrees with the *mental health unit physician*, you may request an appeal in writing as outlined below.

Written Appeal

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

Blue Cross and Blue Shield of Illinois
Behavioral Health Unit
P.O. Box 660241
Dallas, TX 75266-0241

You must exercise the right to this appeal as a precondition to taking any action against the *claims administrator*, either at law or in equity. Once you have requested this review, you may submit additional information and comments on your *claim* to the *claims administrator* as long as you do so within 30 days of the date you asked for a review. Also, during this 30-day period, you may review any relevant documents held by the *claims administrator*, if you request an appointment in writing. Within 30 days of receiving your request for review, the *claims administrator* will send you its decision on the *claim*. In unusual situations, an additional 15 days may be needed for the review and you will be notified of this during the first 30-day period. Additional information about appeals procedures is set forth in the "Filing and ERISA Claim or Appeal" main section.

Failure to Preauthorize or Notify

The final decision regarding your *course of treatment* is solely your responsibility and the *mental health unit* will not interfere with your relationship with any *behavioral health provider*. However, the *mental health unit* has been established for the specific purpose of assisting you in maximizing your benefits as described in this SPD. If you fail to *preauthorize* or notify the *mental health unit* as required under "Preauthorization Requirements" in this main section, you will then be responsible for the first $250 of the *hospital* charges for an eligible *hospital* stay in addition to any *deductibles*, *copays*, and/or *coinsurance* applicable to this SPD. This amount shall not be eligible for later consideration as an unreimbursed expense under any section of this SPD nor can it be applied to your out-of-pocket expense limit, if applicable.

Individual Benefits Management Program ("IBMP")

In addition to the benefits described in this SPD, if your condition would otherwise require continued care in a *hospital* or other health care facility, provision of alternative benefits for services rendered by a *participating provider* in accordance with an alternative treatment plan may be available to you.

Alternative benefits will be provided only so long as the *claims administrator* determines that the alternative services are medically necessary and cost-effective. The total maximum payment for alternative services cannot exceed the total benefits for which you would otherwise be entitled under the Plan.

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

Medicare-Eligible Benefits

The provisions described in this main section do not apply to you if you are *Medicare*-eligible and have secondary coverage provided under the Plan.

Inpatient Behavioral Health and Substance Abuse Treatments

If your *physician* recommends *inpatient* behavioral health or *substance abuse* treatments, you or your *provider* must call Blue Cross Blue Shield Customer Service to *preauthorize* care. **The call must be made before the admission**. Otherwise, the Plan doesn't pay the maximum level of benefits for *eligible expenses*. You may incur a *covered expense* while confined in a *hospital* or *residential treatment facility* to treat alcoholism, drug abuse, or a *mental disorder*. In addition, such *confinement* may not be ordered or prescribed by the *claims administrator*, or the *confinement* may (or any day of such *confinement*) not be certified as necessary. If this is the case, the Plan pays benefits for covered expenses incurred on any day that's not certified during the *confinement* as follows.

- **Hospital and Residential Treatment Facility Room and Board:** If certification is requested and denied, or if certification isn't requested and the *confinement* (or any day of such *confinement*) is considered not necessary, the Plan doesn't pay benefits.

  If certification isn't requested and it's determined that the *confinement* (or any day of such *confinement*) **is necessary**, the Plan doesn't pay benefits for such expenses, up to the excluded amount.

- **All Other Hospital and Residential Treatment Facility Expenses:** If certification is requested and denied, or if certification isn't requested and the *confinement* is considered **necessary**, the Plan doesn't pay benefits for such expenses, up to the excluded amount. If certification isn't requested and it's determined that the *confinement* **isn't necessary**, the Plan doesn't pay benefits.

If—in your *physician's* opinion—it's necessary for you to be confined for a longer time than the days certified, you, your *physician*, or the *hospital* may request that more days be certified. To do so, call Blue Cross Blue Shield Customer Service to *preauthorize* care. The call must be made no later than the last day certified.

The CVS Caremark Prescription Drug Program for the Blue Cross Blue Shield National Coverage Options

Overview

CVS Caremark administers the Prescription Drug Program for the WKUS self-insured Blue Cross Blue Shield coverage options. You have the opportunity to purchase prescription drugs at any participating retail pharmacy, through CVS Caremark's mail service pharmacy, or through Caremark's Specialty Pharmacy.

This main section describes the Plan's Prescription Drug Program as it pertains to the WKUS Blue Cross Blue Shield National coverage options. If you participate in an HMO, your HMO can provide you with prescription drug coverage details.

A Snapshot of Your CVS Caremark Prescription Drug Coverage

The Prescription Drug Program enables you to purchase prescription drugs through participating retail pharmacies, the mail service pharmacy, or Caremark's Specialty Pharmacy.

If you participate in the PPO option, the amount you pay for a prescription drug (your *copay* or *coinsurance*) depends on whether you purchase a *generic* (*copay*), *formulary*, or *non-formulary* brand-name drug (*coinsurance*). It also depends on whether you receive your prescription at a retail pharmacy or through the mail service pharmacy.

In addition, an annual out-of-pocket maximum applies under the PPO option. Once you reach the out-of-pocket maximum for prescription drugs, the PPO option generally will pay 100% of your prescription drug costs for the rest of the year. This out-of-pocket maximum is separate from the medical out-of-pocket limits that are in place for your specific medical option.

If you participate in an HSA option, the Plan pays benefits for eligible prescription drug services similar to how it pays for eligible medical expenses. You generally must meet a *deductible* before the Plan pays benefits; however, the Plan helps pay for certain generic preventive drugs before you've met the deductible. You can review the preventive medication therapy list, as defined by the IRS, at **www.caremark.com**. If you fill your prescriptions at a *participating pharmacy*, mail service pharmacy, or Caremark's Specialty Pharmacy, the Plan pays 90% in-network (under the Enhanced option) and 70% in-network (under the Core option) of *eligible expenses* based on *negotiated fees* after you meet your combined medical/prescription drug *deductible*. No benefits are paid if you use a *non-participating pharmacy*.

Here is a snapshot of your coverage.

<table>
<tr><td></td><td colspan="4">Enhanced HSA Option*</td></tr>
<tr><td></td><td colspan="2">Retail Pharmacy</td><td colspan="2">Mail Service Pharmacy or Specialty Pharmacy</td></tr>
<tr><td>Type of Prescription Drug Service</td><td>You Pay (Applicable HSA Deductible)</td><td>Plan Pays</td><td>You Pay (Applicable HSA Deductible)</td><td>Plan Pays</td></tr>
<tr><td>Annual Out-of-Pocket Maximum</td><td colspan="4">NA</td></tr>
<tr><td>When to Use</td><td colspan="2">For Immediate Prescription Drug Needs or Short-Term Medications</td><td colspan="2">For Long-Term or Maintenance Medications</td></tr>
<tr><td>Generic**</td><td rowspan="3">$1,500 (Employee only)

$2,700 (Employee and Spouse or Children)

$3,000 (Employee and Family)</td><td>90% after deductible (in-network)

Preventive Medication Therapy List Drugs: 90%, no deductible</td><td rowspan="3">$1,500 (Employee only)

$2,700 (Employee and Spouse or Children)

$3,000 (Employee and Family)</td><td>90% after deductible (in-network)

Preventive Medication Therapy List Drugs: 90%, no deductible</td></tr>
<tr><td>Preferred Brand</td><td>90% (after deductible) (in-network)</td><td>90% (after deductible) (in-network)</td></tr>
<tr><td>Non-Preferred Brand</td><td>90% (after deductible) (in-network)</td><td>90% (after deductible) (in-network)</td></tr>
<tr><td>Refill Limit</td><td colspan="2">Two Refills on Long-Term or Maintenance Drugs Only***</td><td colspan="2">None (except for prescription limitations)</td></tr>
<tr><td>Daily Supply Limits</td><td colspan="2">30-Day Supply</td><td colspan="2">90-Day Supply</td></tr>
</table>

** If you choose a preferred brand or non-preferred brand drug when a generic substitution is available, you're responsible for the respective copay plus the difference in cost between the preferred or non-preferred brand drug. If you are not able to take the generic drug due to a medical reason, your physician is able to submit documentation for an exception based on “medical necessity” by contacting CVS Caremark at **1-866-587-4797**. The exception process is subject to approval by CVS Caremark.

*** If your prescribed drug is on the specialty drug list, you may get one fill at a retail pharmacy if available; you'll be required to get future refills through Caremark’s Specialty Pharmacy.

	Core HSA Option*			
	Retail Pharmacy		Mail Service Pharmacy or Specialty Pharmacy	
Type of Prescription Drug Service	**You Pay (Applicable HSA Deductible)**	**Plan Pays**	**You Pay (Applicable HSA Deductible)**	**Plan Pays**
Annual Out-of-Pocket Maximum	NA			
When to Use	For Immediate Prescription Drug Needs or Short-Term Medications		For Long-Term or Maintenance Medications	
Generic[**]	$4,500 (Employee only) $6,750 (Employee and Spouse or Children)	70% after deductible (in-network) Preventive Medication Therapy List Drugs: 70%, no deductible	$4,500 (Employee only) $6,750 (Employee and Spouse or Children)	70% after deductible (in-network) Preventive Medication Therapy List Drugs: 70%, no deductible
Preferred Brand	$9,000 (Employee and Family)	70% (after deductible) (in-network)	$9,000 (Employee and Family)	70% (after deductible) (in-network)
Non-Preferred Brand		70% (after deductible) (in-network)		70% (after deductible) (in-network)
Refill Limit	Two Refills on Long-Term or Maintenance Drugs Only[***]		None (except for prescription limitations)	
Daily Supply Limits	30-Day Supply		90-Day Supply	

[**] If you choose a preferred brand or non-preferred brand drug when a generic substitution is available, you're responsible for the respective copay plus the difference in cost between the preferred or non-preferred brand drug. If you are not able to take the generic drug due to a medical reason, your physician is able to submit documentation for an exception based on “medical necessity” by contacting CVS Caremark at **1-866-587-4797**. The exception process is subject to approval by CVS Caremark.

[***] If your prescribed drug is on the specialty drug list, you may get one fill at a retail pharmacy if available; you'll be required to get future refills through Caremark’s Specialty Pharmacy.

	Blue Cross Blue Shield PPO Option*			
	Retail Pharmacy		**Mail Service Pharmacy or Specialty Pharmacy**	
Type of Prescription Drug Service	**You Pay (Copay)**	**Plan Pays**	**You Pay (Copay)**	**Plan Pays**
Annual Out-of-Pocket Maximum	Individual: $2,100 Family: $4,200			
When to Use	For Immediate Prescription Drug Needs or Short-Term Medications		For Long-Term, Maintenance, or Injectable Medications	
Generic**	$10	100% (after copay)	$20	100% (after copay)
Preferred Brand	30% (min. $35/ max. $60)	100% (after max.)	30% (min. $87/ max. $120)	100% (after max.)
Non-Preferred Brand	45% (min. $65/ max. $90)	100% (after max.)	45% (min. $162/ max. $190)	100% (after max.)
Refill Limit	Two Refills on Long-Term or Maintenance Drugs Only***		None (except for prescription limitations)	
Daily Supply Limits	30-Day Supply		90-Day Supply	

CVS Caremark uses a program called *step therapy* to help manage drug costs within specific therapy classes (such as PPI/Acid Reflux, COX-2 Inhibitors/Pain, HMG/Cholesterol). This is because a particular condition can actually be treated with a number of different medications. *Step therapy* points you to a first-step, lower-cost, clinically effective drug in each therapy group. The program uses evidence-based clinical protocols to select first-step drugs, and its rigorous processes ensure clinical appropriateness by following FDA guidelines, researching medical literature, and relying on input from independent *physicians* and pharmacists. If you take a prescription that is subject to *step therapy,* you will be notified. Until then, to learn more about *step therapy*, contact the *claims administrator*.

Note that there is a process in place to allow you and/or your *physician* to request an exception for medically necessary situations where a first-step drug is inappropriate, and a brand-name must be used.

With CVS Caremark's Generic Copay Incentive program, your pharmacy *copay* will be waived for six months if you switch from brand-name to *generic* medications to treat several targeted conditions. If you participate in a Blue Cross Blue Shield National coverage option and you're eligible for CVS Caremark's Generic Copay Incentive program, you'll be notified by CVS Caremark.

* Rates assume that you're using a participating pharmacy. If you use a non-participating pharmacy, the Plan doesn't pay benefits.

** If you choose a preferred brand or non-preferred brand drug when a generic substitution is available, you're responsible for the respective copay plus the difference in cost between the preferred or non-preferred brand drug. If you are not able to take the generic drug due to a medical reason, your physician is able to submit documentation for an exception based on "medical necessity" by contacting CVS Caremark at **1-866-587-4797**. The exception process is subject to approval by CVS Caremark.

CVS Caremark's Maintenance Choice program allows you to avoid paying more for *long-term medication*. You will need to pick up a 90-day supply of *long-term medications* at CVS *participating pharmacies* or through the CVS Caremark mail service pharmacy. The program will only pay for two refills of a 30-day supply at a network retail pharmacy for *long-term medication*.

CVS Caremark utilizes a specialty pharmacy that delivers high-cost *injectable drugs* used to treat certain chronic diseases. This service is designed to improve delivery and convenience if you or your covered dependent uses these types of medications. CVS Caremark's Specialty Pharmacy ships the drugs and all supplies needed for the injection directly to your home or prescribing *physician's* office. In addition to delivering your medications, the CVS Caremark Specialty Pharmacy team is available by phone at **1-866-587-4797**, 24 hours a day, seven days a week to answer your questions and offer support. They can help you better understand your condition and medication therapy, work directly with your *physician* to confirm that you're on the right therapy, and help ensure that you have the medications and supplies you need for your care. The team of registered *nurses* also can work with you and your caregivers. You can find additional information regarding this coverage under "How Your Prescription Drug Coverage Works" and "Covered Medications, Medical Devices, and Other Covered Expenses" under this main section.

Under the Specialty Guidelines Management program, CVS Caremark will evaluate the clinical effectiveness of prescribed biotech or specialty medications. CVS Caremark will work directly with your doctor and pharmacist to complete this review, and you will be contacted if any action is required on your part.

For members with diabetes, you will be eligible to receive a new connected meter plus unlimited test strips, all at no cost to you, that lets you track and share your blood glucose readings for personalized support. If you're eligible to participate, you will receive targeted communications from CVS with further information on opting into the program.

How Your Prescription Drug Coverage Works

Regardless of which self-insured Blue Cross Blue Shield coverage option you choose, the Plan pays benefits for eligible *outpatient* prescription drug services. The chart below briefly describes how the retail pharmacy and mail service pharmacy operate.

	About Your Coverage			
	Retail Pharmacy		**Mail Service Pharmacy***	
Provision	**PPO Plan**	**Enhanced/Core HSA**	**PPO Plan**	**Enhanced/Core HSA**
Access	You have access to a network of participating pharmacies. These pharmacies agree to charge lower rates for prescription drug services.		You have access to a service that offers the convenience of receiving your prescriptions through the mail.	
Prescriptions When You Need Them	At the point that you fill your short-term prescription, choose any participating retail pharmacy.		The mail service pharmacy is designed to meet your long-term or maintenance medication needs.	
Your Cost	As long as you fill your prescription at a participating pharmacy, all you need to do is pay the *copay* or *coinsurance* (subject to min. and max.), up to the annual out-of-pocket maximum. Once you reach the maximum, the Plan generally will pay 100% of your prescription drug costs for the rest of the year. The amount you have to pay depends on whether you receive a generic, preferred, or non-preferred brand drug. If you fill your prescription at a non-participating pharmac*y*, the Plan doesn't pay benefits.	You may be required to meet your deductible before the Plan pays benefits. If you fill your prescription at a participating pharmacy, the Plan pays 90% (Enhanced) or 70% (Core) of eligible prescription drug expenses. If you fill your prescription at a non-participating pharmac*y*, the Plan doesn't pay benefits.	If you use the mail service pharmacy, you must complete a mail service order form for your first mail service order and meet a copay requirement. Your copay depends on whether you receive a generic, preferred, or non-preferred brand drug. The Plan then mails you your long-term medication.	If you use the mail service pharmacy, you must complete a mail service order form for your first mail service order. After you meet your deductible (if required), the Plan pays 90% (Enhanced) or 70% (Core) of eligible prescription drug expenses. The Plan then mails you your long-term medication.

* CVS Caremark also uses a specialty pharmacy that delivers high-cost *injectable medications* for certain chronic diseases.

	About Your Coverage			
	Retail Pharmacy		Mail Service Pharmacy*	
Provision	**PPO Plan**	**Enhanced /Core HSA**	**PPO Plan**	**Enhanced/Core HSA**
Finding a Pharmacy	You can select a participating pharmacy from the claims administrator's online Directory, or you can call the claims administrator for assistance.		Access a mail service order form through the claims administrator's website at: **www.caremark.com**	

The *Directory* of *participating pharmacies* may change from time to time. Therefore, you should visit the online *Directory* (or contact your *claims administrator*) for the most up-to-date list of *participating pharmacies* each time you fill a prescription. You can also check with your pharmacist before you fill your prescription to make sure that the pharmacy still participates in the network.

About Formulary Drugs

Frequently, several drugs work equally well for a specific medical condition. CVS Caremark ensures that the drugs (called “preferred brand drugs”) they choose for their *formulary* are clinically effective and safe. Through the use of a *formulary*, CVS Caremark can maximize treatment quality, while better managing prescription drug costs.

You may want to ask your *physician* which drugs might work best given your medical condition. Then, check to see whether the suggested prescription is on the *formulary*. Your share of the cost for a preferred brand drug on the *formulary* is considerably less than a non-preferred brand drug. Because the *formulary* may change during the year, you may want to request the most up-to-date copy directly from CVS Caremark, or you can go to their website at **www.caremark.com** for the most up-to-date listing.

How Benefits Are Paid

How the Plan pays benefits depends on:

- Whether you fill your prescription through a retail pharmacy or through the mail service pharmacy.
- What medical option you’re enrolled in—the Blue Cross Blue Shield PPO option or an HSA option.
- Whether you receive a *generic*, preferred brand, or non-preferred brand drug.

If you participate in the Blue Cross Blue Shield PPO option, a *copay* applies to the *generic* drugs you purchase, and a percentage of cost applies to the preferred and non-preferred drugs you purchase. See the snapshot chart for the *copay* or *coinsurance* that applies for each type of prescription. If you're an HSA option participant, you must meet a *deductible* before the Plan pays benefits.

Remember, this is the prescription drug coverage associated with the Blue Cross Blue Shield National coverage options, which is administered by CVS Caremark. If you select an HMO coverage option, your HMO provides your prescription drug coverage. Contact your HMO directly for information about your prescription drug coverage.

The Retail Pharmacy

* CVS Caremark also uses a specialty pharmacy that delivers high-cost *injectable medications* for certain chronic diseases.

You should use the retail pharmacy for your immediate or *short-term prescriptions*. As long as you fill your prescription at a *participating pharmacy*, all you have to do is meet a *copay*/percentage of the cost or *deductible* requirement (depending on your coverage option) before the Plan pays the full cost of your prescription. See the snapshot chart for details. If you fill your prescription at a *non-participating pharmacy*, the Plan doesn't pay benefits at all. Here's some important information regarding the retail pharmacy.

How to Use Participating Pharmacies

To fill a prescription through a *participating pharmacy*:

- Go to any *participating pharmacy*.

  A complete list of *participating pharmacies* is available online, or by calling CVS Caremark. This information is furnished to you automatically and free of charge. However, since the number of *participating pharmacies* continues to grow, you may want to contact CVS Caremark or visit the online *Directory* for an up-to-date list of *participating pharmacies*.

- Present your ID card to the pharmacist. See the “How to Enroll” main section for details.

- If you're a Blue Cross Blue Shield PPO participant, pay your *copay*/percentage of cost requirement at the time you fill your prescription. Your share of the cost is lower if you have your prescription filled with *generic* or preferred brand drugs. You might ask your *physician* (or pharmacist) if your prescriptions may be filled with a *generic* instead of a preferred brand *formulary* or *non-formulary* drug. Under the PPO option, once you meet the annual prescription drug out-of-pocket maximum, the Plan generally will pay 100% of your prescription drug costs for the rest of the year.

  If you're an HSA option participant, you may be required to meet your *deductible* before the Plan pays benefits. You may apply your HSA funds to your *deductible*.

- Sign for and receive your prescription.

You must go to a *participating pharmacy* for the Plan to pay benefits. The Plan doesn't pay benefits if you fill your prescriptions at a *non-participating pharmacy*. In addition, as long as you go to a *participating pharmacy*, you don't have to file a *claim* for the Plan to pay benefits (regardless of your coverage option).

Refills

You may need to have your prescription refilled. If this is the case and your *physician* authorizes a prescription refill, simply bring your prescription bottle or package to the CVS *participating pharmacy*. You also can use the pharmacy's automated refill system (if available).

The Plan limits refills to two 30-day supplies at a retail pharmacy through the Maintenance Choice program. Thereafter, you must request a 90-day supply either through the mail service pharmacy or a CVS *participating pharmacy*.

Limits

The Plan pays benefits for up to a 30-day supply for most medications. However, for certain long-term or maintenance medications, you can obtain larger quantities of over 90 days. For information regarding these maintenance drugs, contact your participating pharmacy or CVS Caremark.

The Mail Service Pharmacy

You can fill your *long-term or maintenance medications* through the mail. With the mail service pharmacy, you must meet a *copay*/percentage of cost or *deductible* (if required, depending on your coverage option) before you receive up to a 90-day supply of your medication. If you are in the Blue Cross Blue Shield PPO option and choose a *generic drug*, you must meet a *copay* requirement; each original prescription or refill requires a *copay*. See the snapshot chart for details regarding your *copay*/percentage of cost or *deductible* requirement. Here's some important information regarding the mail service pharmacy.

How to Use the Mail Service Pharmacy

To fill a prescription through the mail:

- Complete a mail-service form and send it to CVS Caremark. Be sure to include your original prescription (please don't submit copies). A new form and pre-addressed envelope is then sent to you with each delivery.

- Ask your *physician* to write a prescription for a 90-day supply, plus refills, so that you can submit it directly to the mail service pharmacy with your form. If you need medication immediately, ask your *physician* for two prescriptions:
    - One for an immediate supply (you can then take this to your local *participating pharmacy*); and
    - A second one for the long-term supply (you can then submit this one to the mail service pharmacy).

- Mail a mail-service form for each prescription to CVS Caremark. Be sure to include the appropriate *copay/cost share* in the pre-addressed envelope. You will need to pay your cost of the prescription, before you receive your prescription through the mail.

You will receive your prescription within 14 days of the day CVS Caremark receives your order.

Refills

You may need to have your *long-term or maintenance medication* refilled. If this is the case and your *physician* authorizes a prescription refill, you can obtain a refill by any of the following methods:

- **Mail:** Attach a refill label from your prescription order to a mail-order form. Then, mail it with the appropriate payment to CVS Caremark in the pre-addressed envelope.

- **Telephone:** To reach a customer services representative, call CVS Caremark at **1-866-587-4797**. This is the automated 24-hour-a-day toll-free line.

- **Online:** Log on to **www.caremark.com** to place refill orders, check the status of orders, and locate participating pharmacies. The Plan does limit refills to a 90-day supply.

Limits

The Plan pays benefits for up to a 90-day supply of *long-term or maintenance medications*.
For information regarding these maintenance drugs, contact your *participating pharmacy* or CVS Caremark.

Generic Substitutions for Brand-Name Medications

The participating pharmacy will substitute an available *generic* medicine for a brand-name medicine, unless the doctor indicates “Dispense as Written” on the prescription.

If you choose to take a brand-name drug that has a direct *generic* equivalent, you will pay the difference in cost between the brand-name and the *generic* drug plus the *generic copay*.

If for some medical reason the patient is unable to take the *generic* drug, his or her doctor can submit information for an exception based on “medical necessity” by contacting CVS Caremark at **1-866-587-4797**. The criteria to be used in justifying medical necessity are:

- If the use of the medication could harm rather than help the patient;
- The patient experiences or is likely to experience significant adverse effects from the *generic* medication and is reasonably expected to tolerate the brand-name medication;
- The *generic* medication results in therapeutic failure (meaning the medication is not effective, as determined by the patient’s *provider*), and the patient is reasonably expected to respond to the brand-name medication; or
- The patient previously responded to the brand-name medication and changing to the *generic* would incur unacceptable clinical risk.

Self-Injectable Drugs—Specialty Pharmacy Network Benefits

Self-injectable drugs are covered at the network level of benefits only when dispensed through a network retail pharmacy or CVS Caremark's Specialty Pharmacy network. You may refer to CVS Caremark's website, **www.CVSCaremarkSpecialtyRx.com** to review the preferred drug guide for a list of *self-injectable drugs* anytime. The list may be updated from time to time.

The initial prescription for a *self-injectable drug* may be filled at a network retail pharmacy, if available or at CVS Caremark's Specialty Pharmacy. After the initial fill, you're required to obtain *self-injectable drugs* at CVS Caremark's Specialty Pharmacy network.

Covered Medications, Medical Devices, and Other Covered Expenses

The Plan pays benefits for many prescription drugs, medications, medical devices, and other covered expenses. You may refer to CVS Caremark's website anytime at **www.caremark.com** to review the preferred drug guide and confirm the list of covered drugs. The list may be updated from time to time.

Other Covered Expenses

The following prescription drugs, medications, and supplies are also covered expenses under your prescription drug coverage.

- **Off-Label Use:** FDA-approved prescription drugs may be covered when the off-label use of the drug hasn't been approved by the FDA for that indication. The drug must be recognized for treatment of the indication in one of the standard compendia (the United States Pharmacopoeia Drug Information, the American Medical Association Drug Evaluations, or the American Hospital Formulary Service Drug Information). Or, the safety and effectiveness of use for this indication must be adequately demonstrated by at least one study published in a nationally recognized peer review journal. Coverage of off-label use of these drugs may be provided by the *claims administrator's* sole discretion and may be subject to requirements or limitations.

- **Diabetic Supplies:** The following diabetic supplies may be covered upon prescription by a *physician*:
  - Diabetic needles and syringes;
  - Test strips for glucose monitoring and/or visual reading;
  - Diabetic test agents;
  - Lancets/lancing devices; and
  - Alcohol swabs.

  In addition, you will be eligible to receive a new connected meter plus unlimited test strips, all at no cost to you, that lets you track and share your blood glucose readings for personalized support. If you’re eligible to participate, you’ll receive targeted communications from CVS.

- **Contraceptives for Women:** The Plan provides 100% coverage, with no *deductible*, for FDA-approved, *generic* contraceptives (and brand-name contraceptives with no available *generic* form) as defined by the U.S. Food and Drug Administration's Birth Control Guide and recommended by your *physician*.

  The Plan also provides 100% coverage for non-preferred brands with a doctor's instruction to “Dispense as Written” (DAW), as well as for over-the-counter (OTC) contraceptives.

  Examples include:
  - Barrier contraceptive methods (diaphragms and cervical caps);
  - Hormonal contraceptive methods (oral, transdermal, intravaginal, and *injectable*);
  - Emergency contraceptive methods, either by prescription or over the counter (e.g., Plan B and Ella);
  - Implantable medications (e.g., Implanon);
  - Intrauterine contraceptives (e.g., Mirena, Skyla);
  - OTC contraceptive devices (e.g., non-spermicidal condoms); and
  - OTC contraceptive medications (e.g., anything with a spermicide).

- **Lifestyle/Performance Drugs:** Sildenafil Citrate, phentolamine, apomorphine, and alprostadil in oral, *injectable*, and topical (including but not limited to gels, creams, ointments, and patches) forms or any other form used internally or externally. Expenses include any prescription drug in oral or topical form that's similar or identical in class, has a similar or identical mode of action, or exhibits similar or identical outcomes. Coverage is limited to six pills or other form (as determined cumulatively among all forms) for unit amounts as determined by the *claims administrator* to be similar in cost to oral forms, per 30-day supply. Mail order and 60- to 90-day supplies aren't covered.

The snapshot chart details how the Plan pays benefits for each type of prescription. And, CVS Caremark's website mentioned above lists all of the medications, medical devices, and other expenses that the Plan covers. **Remember, if you're an HMO participant, your HMO can provide detailed terms and conditions regarding your covered prescription drug services.**

Prescriptions Not Covered

Not every health care service or supply is covered by the Plan, even if prescribed, recommended, or approved by your *physician* or *dentist*. The Plan covers the following services and supplies that are medically necessary, to the extent they're specifically stated under the “What the Plan Covers” main section, or to the extent they're described within an amendment attached to this SPD. In addition, some limits or exclusions apply to specific services.

This subsection describes expenses that the Plan doesn't cover, or expenses that are subject to special limitations. These prescription drug exclusions are in addition to the exclusions listed under the “What the Plan Doesn't Cover” main section. The Plan doesn't cover the following expenses.

- Administration or injection of any drug.

- Any charges in excess of the benefit, dollar, day, or supply limits stated in this SPD.

- Any refill dispensed more than one year from the date of the latest prescription order, or as otherwise permitted by applicable law of the jurisdiction in which the drug is dispensed.

- Allergy sera and extracts.

- Any non-emergency charges incurred outside of the United States if:
    - You traveled to such location to obtain prescription drugs or supplies, even if otherwise stated as covered in this SPD; or
    - Such drugs or supplies are unavailable or illegal in the United States (purchase of such prescription drugs or supplies outside the United States is considered illegal).

- Any drugs or medications, services, and supplies that aren't medically necessary as determined by the *claims administrator* for the diagnosis, care, or treatment of the *illness* or *injury* involved. This applies even if they're prescribed, recommended, or approved by your *physician* or *dentist*.

- Biological sera, blood, blood plasma, blood products or substitutes, or any other blood products.

- Contraception supplies and services, including:
    - Over-the-counter (OTC) contraceptive supplies (except for women's OTC *generic* contraceptives with a *physician's* prescription), including but not limited to, condoms, contraceptive foams, jellies, and ointments; and
    - Services associated with the prescribing, monitoring, and/or administration of contraceptives.

- *Cosmetic* drugs, medications, or preparations used for *cosmetic* purposes or to promote hair growth, including but not limited to:
    - Health and beauty aids;
    - Chemical peels;
    - Dermabrasion treatments; and
    - Bleaching, creams, ointments, or other treatment and supplies to remove tattoos, scars, or to alter the appearance or texture of the skin.

- Drugs administered or entirely consumed at the time and place they're prescribed or dispensed.

- Drugs that don't, by federal or state law, require a prescription order (i.e., OTC drugs), even if a prescription is written.

- Drugs provided by, or while the person is an *inpatient* in, any health care facility; or any drugs provided on an *outpatient* basis by any such institution to the extent benefits are payable.

- Drugs used primarily to treat *infertility*, or for or related to artificial insemination, including in-vitro fertilization or embryo transfer procedures (except as described under the “What the Plan Covers” main section).

- Drugs taken to reduce or gain weight, including but not limited to:
    - Stimulants;
    - Preparations;
    - Foods or diet supplements;
    - Dietary regimens and supplements;
    - Food or food supplements;
    - Appetite suppressants; and
    - Other medications.

- Drugs used to treat obesity.

- All drugs or medications in a *therapeutic drug class*, if one of the drugs in that *therapeutic drug class* isn't a prescription drug.

- *Durable medical equipment*, monitors, and other equipment.

- *Experimental or investigational* drugs or devices, except as described under the “What the Plan Covers” main section. This exclusion doesn't apply with respect to drugs that:
    - Have been granted treatment Investigational New Drug (IND) or Group C/treatment IND status;
    - Are being studied at the Phase III level in a national clinical trial sponsored by the National Cancer Institute; or
    - The *claims administrator* determines, based on available scientific evidence, are effective or show promise of being effective for the *illness*.

- Food items, including:
    - Infant formulas;
    - Nutritional supplements;
    - Vitamins, including prescription vitamins; and
    - Medical foods and other nutritional items (even if it's the sole source of nutrition).

- Genetics, including any treatment, device, drug, or supply designed to alter the body's genes, genetic make-up, or the expression of the body's genes (except to correct congenital birth defects).

- Immunization or immunological agents, including but not limited to:
    - Biological sera;
    - Blood plasma or other blood products administered on an *outpatient* basis;
    - Allergy sera; and
    - Testing materials.

- Implantable drugs and associated devices.

- *Injectable*s, including:
    - Any charges associated with the administration or injection of prescription drugs or *injectable* insulin and other *injectable drugs* covered by CVS Caremark;
    - *Injectable* agents, except insulin;
    - Needles and syringes, including but not limited to diabetic needles and syringes;
    - *Injectable drugs* if an alternative oral drug is available; and
    - Refills of a designated *self-injectable drug* that's not dispensed by or obtained through the Specialty Pharmacy network (an updated list of *self-injectable drugs* designated by this Plan to be refilled by or obtained through the Specialty Pharmacy network is available upon request or may be accessed at CVS Caremark's website at **www.CVSCaremarkSpecialtyrx.com**).

- Insulin pumps, tubing, or other ancillary equipment or supplies associated with insulin pumps.

- Prescription drugs for which there's an over-the-counter product that has the same active ingredient and strength, even if a prescription is written.

- Prescription drugs, medications, *injectable*s, or supplies provided through a third-party vendor contract with the contract holder.

- Any treatment, drug, service, or supply to:
    - Stop or reduce smoking;
    - Stop or reduce the use of other tobacco products; or
    - Treat or reduce nicotine addiction, dependence, or cravings (including medications, nicotine patches, and gum).

- Strength and performance drugs or preparations, devices, and supplies (including performance-enhancing steroids) taken to enhance:
    - Strength;
    - Physical condition; or
    - Endurance or physical performance.

- Any treatment, drugs, or supplies related to changing sex or sexual characteristics, including hormones and hormone therapy.

- Any drug or supply that's taken to treat sexual dysfunction, enhance sexual performance, or increase sexual desire, including drugs, implants, devices, or preparations to:
    - Correct or enhance erectile function;
    - Enhance sensitivity; or
    - Alter the shape or appearance of a sex organ.

- Medical supplies, devices, or equipment of any type (except as specifically stated as a *covered expense* under the “What the Plan Covers” main section).

- Drugs prescribed for uses other than uses:
    - Approved by the Food and Drug Administration (FDA) under the Federal Food, Drug, and Cosmetic Law and regulations;
    - Labeled “Caution: Limited by Federal Law to Investigational Use”; or
    - That are considered experimental (experimental drugs).

- Test agents, except diabetic test agents.

Applying for Benefits—Prescription Drugs

As long as you receive care from a *participating pharmacy*, you don't have to file a *claim* for benefits.

Appeals

Formal procedures are in place if you need to appeal a benefit decision relative to your prescription drug services. The same appeals process that applies for medical benefit decisions applies for prescription drug benefit decisions. Therefore, please see the “Filing an ERISA Claim or Appeal” main section for details regarding the appeals process.

The Well-being Program

About the Program

Wolters Kluwer is committed to your health by offering the Wolters Kluwer Well-being Program called “Be Well.” The goal of Be Well is to establish a work environment that promotes healthy lifestyles, decreases the risk of disease, and enhances the quality of life.

Taking responsibility for your health and well-being is an essential part of healthy living and productivity. Be Well intends to promote positive change in all areas of health and well-being, including physical, social, financial, and intellectual.

The following are available to you and your covered spouse/domestic partner through the Well-being Program:

- Online health assessment;
- Free preventive annual exams (if billed as preventive);
- Financial incentives to help you reach your weight goals;
- Rewards for being active;
- Wellbeing Webinars;
- Smoking cessation assistance; and
- Other health and wellness assistance.

More information about the Well-being Program is posted on the Be Well website, **https://wolterskluwer.biovia.healthfitness.com** under About Program > Well-Being Resources**.**

The Life Resources Program (LRP)

About the LRP

Life isn't always easy, and everyone needs help from time to time. Because the personal health and well-being of you and your family is important, the *Company* offers the WKUS Life Resources Program (the “Plan” or “LRP”).

The LRP is an important part of your WKUS benefits. It's designed to offer a highly professional, confidential source to help eligible employees and their immediate family members cope with personal problems. The *Company* contracts with ComPsych to administer the LRP. You can connect with ComPsych by phone or online at:

- **Phone: 1-844-658-1544 / TDD: 800-697-0353**
- **Online: guidanceresources.com (company Web ID: WKLRP)**

You're not required to make any contributions. The *Company* pays the full cost of the LRP's services. However, if you're referred to (and elect) services or treatment from a counselor other than one associated with ComPsych, you'll be responsible for the cost of such services. Please note, however, that these costs may be covered as an *eligible expense* under the WKUS Health Plan.

Who's Eligible to Use the LRP

As long as you meet the WKUS Health Plan's eligibility requirements, you're eligible for the LRP. The LRP is also available to your family members who meet the WKUS Health Plan's eligibility requirements. You don't need to enroll in a medical coverage option to take advantage of the LRP's services. Also, if you continue any coverage through *COBRA* continuation, you're also eligible to participate.

How the LRP Works

If you or a family member is finding it difficult to cope with a transitional period—such as the birth of a child, starting a new career, buying a house, or grieving the loss of a family member or close friend—the LRP offers brief, solution-focused resources for many of life’s challenges. Whether you're looking for general information on health and wellness topics, or you're ready to seek personalized assistance, LRP services can help.

The LRP is easy to access. Just call the toll-free number any time of the day or night. An experienced counselor is ready to talk with you, discuss your needs, explain your program, and help direct you to the appropriate services. The LRP provides for one to eight free confidential counseling sessions for any issue you may face. If additional services are needed, your counselor will help you find cost-effective treatment via a referral to a *provider* in your area. Based on the medical coverage option in which you're enrolled, you can obtain a list of participating providers in your area by calling the *claims administrator's* member services number or by searching providers on the Your Benefits Resources website.

The LRP's Services

The LRP offers a wide variety of services.

- **Confidential Counseling**. This no-cost counseling service helps you address stress, relationship, and other personal issues you and your family may face. It's staffed by GuidanceConsultants℠ – highly trained master's and doctoral level clinicians who listen to your concerns and quickly refer you to in-person counseling and other resources for:
  - Stress, anxiety and depression
  - Relationship/marital conflicts
  - Problems with children
  - Job pressures
  - Grief and loss
  - Substance abuse
- **Financial Information and Resources:** Speak by phone with Certified Public Accountants and Certified Financial Planners on a wide range of financial issues, including:
  - Getting out of debt
  - Credit card or loan problems
  - Tax questions
  - Retirement planning
  - Estate planning
  - Saving for College
- **Legal Support and Resources:** Talk to attorneys by phone. If you require representation, you'll be referred to a qualified attorney in your area for a free 30-minute consultation with a 25% reduction in customary legal fees thereafter. Call about:
  - Divorce and family law
  - Debt and bankruptcy
  - Landlord/tenant issues
  - Real estate transactions
  - Civil and criminal actions
  - Contracts
- **Work-Life Solutions:** Work-Life specialists will do the research for you, providing qualified referrals and customized resources for:
  - Child and elder care
  - Moving and relocation
  - Making major purchases
  - College planning
  - Pet care
  - Home repair
- **LifeResources Online:** Expert information on the issues that matter most to you – relationships, work, school, children, wellness, legal, financial, free time, and more.
  - Timely articles, HelpSheets℠, tutorials, streaming videos, and self-assessments
  - "Ask the Expert" personal responses to your questions
  - Child care, elder care, attorney, and financial planner searches

Confidentiality

When you reach out to the LRP on your own behalf or on behalf of a family member, you're assured confidentiality. The *Company* isn't aware of your participation unless you request it, and the private discussions you have with your counselor aren't disclosed to anyone. If you want the *Company* to be aware of your participation and progress, you'll be asked to sign a release form.

Health Advocate

You have confidential access to a Personal Health Advocate, typically a registered nurse, supported by medical directors and benefits and claims specialists who can help you:

- Find the right doctors, hospitals, and other providers; as well as secure second opinions;
- Research treatments;
- Help schedule appointments and tests and transfer medical records;
- Resolve billing and insurance claims issues;
- Transition to retirement;
- Clarify benefits coverage;
- Obtain services for elderly parents and parents-in-law; and
- Identify alternative resources for services that may not be covered by your health plan

To contact a Health Advocate, you can call **1-866-695-8622**, or visit **HealthAdvocate.com/members**.

Filing an ERISA Claim or Appeal

How to File a Claim

If you see a *network provider,* the *provider* generally will file a *claim* for you. If you see a *non-network provider*, you will need to file your own *claim*. You must request your benefits or file a *claim* by December 31 of the year after the year in which you received the service or the onset of *illness* or *injury*, whichever is later. If your claim is not received by the claims administrator on or before the deadline, your *claim* will be denied. If you have coverage under a fully insured option, the *claims administrator* (insurer) will specify the time frame for submitting *claims*. If no time frame is specified, it is presumed that the time frame will be **one year**.

If your *valid claim* is denied (in whole or in part), you have the right to know why, obtain copies of documents that relate to the Plan's decision (without charge), and appeal any denial.

There are two types of issues that you can appeal, *benefit issues* and *eligibility issues*. The appeals process is described in detail below. Prior to an appeal, the Participant Advocacy Group is also available to informally assist you if you have a question or concern about benefits, or a *benefit issue* or *eligibility issue* decision. This main section describes the process in place if you need to appeal a *benefit issue* or *eligibility issue* decision.

Health Advocate—Provides Assistance If You Have Questions

If you have a question about benefits, a benefit amount, or how a benefit claim was paid, you can contact Health Advocate. Before you submit a formal appeal to the claims administrator, you may want to consider utilizing Health Advocate to try to resolve your issue beforehand.

Health Advocate can research and work with the claims administrator to try to resolve your issue before you file a formal appeal. If Health Advocate is unable to resolve your issue, formal appeals procedures are in place. Regardless of whether you utilize Health Advocate, you have the right to appeal your claim once you receive an adverse benefit determination. See "Opportunity to File an Appeal" under this main section for details.

About the Appeals Process

Disagreements about benefit eligibility or benefit amounts can arise. If the *claims administrator* or insurance company (in the case of an HMO) is unable to resolve the disagreement, Wolters Kluwer and the *claims administrators* have formal appeal procedures in place for the Plan in accordance with the Employee Retirement Income Security Act of 1974 (ERISA). This section explains the steps you or your authorized representative is required to take to file a *claim* or appeal.

If you select an HMO option, refer to your HMO materials for details on the appeals process.

Changes to Health Claims and Appeals Procedures Under Health Care Reform

The Affordable Care Act made a few critical changes to the *claims* and appeals procedure, as described below. You should be aware of the following key changes to the *claims* and appeals procedures for **medical** benefits.

- Steps 1 and 2 of the *claims* and appeals process as described below are referred to as the "internal" *claims* and appeals process.
- Generally, medical benefit *claims* (not eligibility *claims*) are eligible for an external review by an Independent Review Organization (IRO)/External Review Organization (ERO). Rescissions or retroactive terminations of coverage, which generally will not occur, also are eligible for an external review. The following general rules apply to external reviews:
    - You will be provided with information regarding this external review if you are denied after completing Step 2 of the *claims* and appeals process. You generally cannot request an external review unless you have exhausted the internal appeals process (received a denial at Steps 1 and 2). The details applicable to this external review can be obtained from your *claims administrator*.
    - To be eligible for the external review, your request must be filed within four months after the date of receipt of a notice of a final internal adverse benefit determination (completion of Step 2).
    - Within five business days following the date of receipt of the external review request, the Plan must complete a preliminary review of the request to determine whether:
        - The claimant is or was covered under the Plan at the time the *medical care*, item, or service was requested;
        - The adverse benefit determination does not relate to the claimant's failure to meet the eligibility requirements under the terms of the Plan, except for a rescission (again, external review generally does not apply to eligibility-type requests or *claims*);
        - The claimant has exhausted the Plan's internal appeal process; and
        - The claimant has provided all the information and forms required to process the external review.
    - The *claims administrator* must assign an ERO to conduct the external review. The ERO will timely notify the claimant in writing of the acceptance for external review. Specific time frames for corresponding with you apply based on interim final rules issued by the U.S. Department of Labor and related agencies, as described below.

If you select an HMO option, refer to your HMO materials for details on the appeals process.

Additional changes apply to medical *claims* under the Affordable Care Act, such as additional content in benefit determination letters. If you have any questions regarding the ERISA *claims* and appeals process, the U.S. Department of Labor website at **http://www.dol.gov/ebsa/healthreform/** will maintain up-to-date information, or you can contact Your Benefit Resources Customer Service Center.

Additional information regarding external reviews is provided below.

The following also applies to all medical *claims*:

The *claims* and appeals procedure is slightly different, depending on whether you have an "**eligibility**" *claim* or a "**benefit**" *claim*. An **eligibility** *claim* is a *claim* to participate in a plan or plan option or to change an election to participate during the year. A **benefit** *claim* is a *claim* for a particular benefit under a plan. It typically will include your initial request for benefits.

About the Four Appeal Sub-Categories

Benefit issues and *eligibility issues* related to the Plan fall within one of four appeal sub-categories. These sub-categories drive the process for how to submit an appeal. They also define the timing that's involved to review appeals. Here are the four appeal sub-categories:

- **Pre-Service:** A pre-service appeal is an appeal for a benefit for which the Plan requires precertification.
- **Post-Service:** A post-service appeal is an appeal for reimbursement of dental services that are already received. This is the most common type of appeal.
- **Urgent Care:** An *urgent care* appeal is an appeal for dental care or treatment that, if the longer time frames for non-*urgent care* were applied, the delay:
    - Could seriously jeopardize the health of the patient or his or her ability to regain maximum function; or
    - In the opinion of a *physician* with knowledge of the patient's medical condition, would subject the patient to severe pain that couldn't be managed without the care or treatment that's the subject of the appeal.
- **Concurrent Care:** A concurrent care appeal is an appeal for ongoing treatment over a period of time or a number of treatments. For example, you may receive authorization to receive a certain number of treatments. If, during the treatment, the provider suggests you receive more treatments than the amount originally authorized, your appeal is considered a concurrent care appeal. Some concurrent care appeals also are *urgent care* appeals.

See "Opportunity to File an Appeal" under this main section for details.

General Procedure	Post-Service Claim	Pre-Service Claim	Concurrent Care Claim	Urgent Care Claim
Step 1:				
How to file a claim To file an **eligibility** claim, request a Claim Initiation Form from the Your Benefits Resources Customer Service Center. You (or your authorized representative) must return the form to the Your Benefits Resources Customer Service Center at the address on the form. To file a **benefit** claim, you (or your authorized representative) should write to your health plan. See the "Administrative Information" section for contact information or refer to the telephone number and/or website shown on the back of your ID card. You must include: ▪ A description of the benefits for which you are applying. ▪ The reason(s) for the request. ▪ Relevant documentation.				To file an urgent care claim, you should contact the Your Benefits Resources Customer Service Center or your health plan. In addition, you must state that you are filing an urgent care claim.
What happens if you do not follow procedure If you misdirect your claim but provide sufficient information to an individual who is responsible for benefits administration, you will be notified of the proper procedure within **(see columns to the right)** of receipt of the claim.	Not applicable. Response time frame does not begin until claim is properly filed.	5 days	Not applicable. Response time frame does not begin until claim is properly filed. If claim involves urgent care, 24 hours.	24 hours

General Procedure	Post-Service Claim	Pre-Service Claim	Concurrent Care Claim	Urgent Care Claim
When you will be notified of the claim decision You will be notified of the decision within **(see columns to the right)** of the Your Benefits Resources Customer Service Center's receipt of your Claim Initiation Form or the health plan's receipt of your claim letter.	30 days This period may be extended for 15 days. You will be notified within the initial 30-day period.	15 days This period may be extended for an additional 15 days. You will be notified within the initial 15-day period.	A time period sufficiently in advance of the reduction or termination of coverage to allow you to appeal and obtain a response to that appeal before your coverage is reduced or terminated. For concurrent care that is urgent, within 24 hours (provided that you submitted a claim at least 24 hours in advance of reduction or termination of coverage); otherwise, within 72 hours.	72 hours

General Procedure	Post-Service Claim	Pre-Service Claim	Concurrent Care Claim	Urgent Care Claim
Failure to provide sufficient information procedure If you fail to provide sufficient information, the claim ***may*** be decided based on the information provided. If the claims fiduciary decides to request additional information before deciding the claim, the Your Benefits Resources Customer Service Center or health plan may notify you within **(see columns to the right)** that additional information is needed.	30 days	15 days	Decision will be based on information provided, unless the concurrent care claim involves urgent care; see urgent care time frame.	24 hours
You will have **(see columns to the right) from receipt of the notice** to provide the additional information. Otherwise, the claim will be decided based on information originally provided.	45 days	45 days		48 hours
If you provide additional information, you will be notified of the decision by the Your Benefits Resources Customer Service Center or health plan within **(see columns to right)**.	The time period remaining for the initial claim.	The time period remaining for the initial claim.		48 hours

General Procedure	Post-Service Claim	Pre-Service Claim	Concurrent Care Claim	Urgent Care Claim
How you will be notified of the claim decision If your claim is approved, the Your Benefits Resources Customer Service Center or the health plan will notify you in writing. For benefit claims, this notification is commonly referred to as an Explanation of Benefits or EOB. If your claim is denied, in whole or in part, the Your Benefits Resources Customer Service Center or the health plan will notify you in writing, except for urgent care. Your denial notice will contain: ▪ The specific reason(s) for the denial. ▪ The Plan provisions on which the denial was based. ▪ Any additional material or information you may need to submit to complete the claim. ▪ Any internal procedures or clinical information on which the denial was based (or a statement that this information will be provided free of charge, upon request). ▪ The Plan's appeal procedures.				If your claim is denied, the Your Benefits Resources Customer Service Center or the health plan will notify you by telephone. Within 3 days of this oral denial, you will receive a written denial notice, as explained under the general procedure. The denial notice also will explain the expedited review process**.**

General Procedure	Post-Service Claim	Pre-Service Claim	Concurrent Care Claim	Urgent Care Claim
Step 2:				
About appeals and the claims fiduciary Before you can bring any action at law or in equity to recover Plan benefits, you must exhaust this process. Specifically, you must file an appeal, as explained in this Step 2, and the appeal must be finally decided by the claims fiduciary. The Wolters Kluwer Appeals Committee is the claims fiduciary for all eligibility claims. The Wolters Kluwer Appeals Committee has delegated its authority to finally determine claims to the health plans for benefit claims. The claims fiduciary is authorized to finally determine appeals and interpret the terms of the Plan in its sole discretion. All decisions by the claims fiduciary are final and binding on all parties.				
How to file an appeal If your claim is denied and you want to appeal it, you must file your appeal within **(see columns to the right)** from the date you receive notice of your denied claim. You may request access, free of charge, to all documents relating to your appeal. If you have an appeal for **eligibility** (i.e., you wrote to the Your Benefits Resources Customer Service Center at Step 1), write to the address specified on your claim denial notice. Also see "Eligibility Issue Appeals" under this main section for more information. If you have an appeal for **benefits** (i.e., you wrote to your health plan at Step 1), write to: Blue Cross Blue Shield of Illinois Claim Review Section P.O. Box 2401 Chicago, IL 60690	180 days	180 days	Within a reasonable period of time, considering the time period scheduled for reduction or termination of benefits	180 days You may **orally** file your appeal with the claims administrator. At the time your claim is denied, the Your Benefits Resources Customer Service Center or the health plan will give you instructions about how to file your appeal, including who the claims administrator is. You must identify that you are appealing an urgent care claim.

General Procedure	Post-Service Claim	Pre-Service Claim	Concurrent Care Claim	Urgent Care Claim
You should include: ▪ A copy of your claim denial notice. ▪ The reason(s) for the appeal. ▪ Relevant documentation. The individual/committee (and any medical expert) reviewing your appeal will be independent from the individual/committee who reviewed your claim. In addition, if your appeal involves a medical judgment, the claims administrator will consult with a health care professional who has appropriate relevant experience. You are entitled to learn the identity of such an expert, upon request.				
When you will be notified of the appeal decision You will be notified of the decision within **(see columns to the right)** of the claims administrator's receipt of your appeal.	**Eligibility appeals:** 60 days **Benefit appeals:** 60 days	**Eligibility appeals:** 30 days **Benefit appeals:** 30 days	**Eligibility and benefit appeals:** Before a reduction or termination of benefits would occur. If the concurrent claim involves urgent care, 72 hours.	**Eligibility and benefit appeals:** 72 hours
How you will be notified of the appeal decision If your appeal is **approved or denied**, the claims administrator will notify you in writing. If your appeal is **denied**, in whole or in part, your denial notice will contain: ▪ The specific reason(s) for the denial. ▪ A statement regarding the documents to which you are entitled, upon request and free of charge. ▪ An explanation of the voluntary appeal procedures (external review for medical plan benefit appeals), if any, and your right to bring a civil action under Section 502(c) of ERISA. ▪ Any internal procedures or clinical information on which the denial was based (or a statement that this information will be provided free of charge, upon request). ▪ The Plan provisions on which the denial was based. ▪ Additional information regarding your rights and next steps, as applicable.				

General Procedure	Post-Service Claim	Pre-Service Claim	Concurrent Care Claim	Urgent Care Claim
Step 3:				
How to proceed if necessary There are 3 levels of appeal available if you receive an adverse benefit decision on an eligibility issue. See "Eligibility Issue Appeals" under this main section for more information. When a health plan is the claims administrator, the health plan offers one mandatory appeal. If your benefit claim is denied following the mandatory appeal, i.e., benefit determination on review, you generally have a right to file a civil action. However, under the Affordable Care Act changes to benefit claims procedures, you also have a right to submit an external review to an IRO for any medical benefit claim. You should contact the claims administrator for more details.				

External Review for Health Claim Appeals

As part of the passage of the Affordable Care Act, a voluntary external review option is available for adverse benefit determinations that do not relate to failure to meet the eligibility requirements under the Plan. The *claims administrator* will coordinate the external review.

"External review" is a review of an adverse benefit determination or a final internal adverse benefit determination by an Independent Review Organization (IRO)/External Review Organization (ERO) or by the State Insurance Commissioner, if applicable.

A "final external review decision" is a determination by an ERO at the conclusion of an external review.

You must complete all of the levels of the standard appeal described above before you can request an external review, other than in a case of deemed exhaustion. Subject to verification procedures that the Plan may establish, your authorized representative may act on your behalf in filing and pursuing this voluntary appeal.

The Notice of Adverse Benefit Determination or Final Internal Adverse Benefit Determination that you receive from the *claims administrator* will describe the process to follow if you wish to pursue an external review, and will include a copy of the Request for External Review Form.

You must submit the Request for External Review Form to the *claims administrator* within four months of the date you received the Adverse Benefit Determination or Final Internal Adverse Benefit Determination Notice. If the last filing date would fall on a Saturday, Sunday, or federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or federal holiday. You also must include a copy of the Notice and all other pertinent information that supports your request.

If you file a voluntary appeal, any applicable statute of limitations will be tolled while the appeal is pending. The filing of a *claim* will have no effect on your rights to any other benefits under the Plan. However, the appeal is voluntary, and you are not required to undertake it before pursuing legal action.

If you choose not to file for voluntary review, the Plan will not assert that you have failed to exhaust your administrative remedies because of that choice.

Request for External Review

The external review process under this Plan gives you the opportunity to receive review of a final internal adverse benefit determination (Step 2) (or an adverse benefit determination (Step 1) if the *claims administrator* or Plan did not strictly adhere to all *claim* determination and appeal requirements under federal law). Your request will be eligible for external review if the following are satisfied:

- The *claims administrator*, or the Plan or its designee, does not strictly adhere to all *claim* determination and appeal requirements under federal law;
- The standard levels of appeal have been exhausted; or
- The appeal relates to a rescission, defined as a cancellation or discontinuance of coverage which has retroactive effect.

An adverse benefit determination based upon your eligibility is not eligible for external review.

If, upon the final standard level of appeal, the coverage denial is upheld and it is determined that you are eligible for external review, you will be informed in writing of the steps necessary to request an external review.

An Independent Review Organization (IRO) refers the case for review by a neutral, independent clinical reviewer with appropriate expertise in the area in question. The decision of the independent external expert reviewer is binding on you, the *claims administrator* and the Plan unless otherwise allowed by law.

Preliminary Review

Within five business days following the date of receipt of the request, the *claims administrator* must provide a preliminary review determining: you were covered under the Plan at the time the service was requested or provided, the determination does not relate to eligibility, you have exhausted the internal appeals process (unless deemed exhaustion applies), and you have provided all paperwork necessary to complete the external review.

Within one business day after completion of the preliminary review, the *claims administrator* must issue to you a notification in writing. If the request is complete but not eligible for external review, such notification will include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration (toll-free number **1-866-444-EBSA (3272)**). If the request is not complete, such notification will describe the information or materials needed to make the request complete and the *claims administrator* must allow you to perfect the request for external review within the 123-calendar-day filing period or within the 48-hour period following the receipt of the notification, whichever is later.

Referral to External Review Organization (ERO)

The *claims administrator* will assign an ERO, accredited as required under federal law, to conduct the external review. The assigned ERO will timely notify you in writing of your eligibility and acceptance for external review, and will provide an opportunity for you to submit in writing within 10 business days following the date of receipt, additional information that the ERO must consider when conducting the external review.

The ERO will review all of the information and documents timely received. In reaching a decision, the assigned ERO will review the *claim* and not be bound by any decisions or conclusions reached during the Plan's internal *claims* and appeals process. In addition to the documents and information provided, the assigned ERO, to the extent the information or documents are available and the ERO considers them appropriate, will consider the following in reaching a decision:

- Your medical records;
- The attending health care professional's recommendation;
- Reports from appropriate health care professionals and other documents submitted by the Plan or issuer, you, or your treating *provider*;
- The terms of your Plan to ensure that the ERO's decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law;
- Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the federal government, national or professional medical societies, boards, and associations;
- Any applicable clinical review criteria developed and used by the *claims administrator*, unless the criteria are inconsistent with the terms of the Plan or with applicable law; and
- The opinion of the ERO's clinical reviewer or reviewers after considering the information described in this notice to the extent the information or documents are available and the clinical reviewer or reviewers consider them appropriate.

The assigned ERO must provide written notice of the final external review decision within 45 days after the ERO receives the request for the external review. The ERO must deliver the notice of final external review decision to you, the *claims administrator*, and the Plan.

After a final external review decision, the ERO must maintain records of all *claims* and notices associated with the external review process for six years. An ERO must make such records available for examination by the claimant, Plan, or state or federal oversight agency upon request, except where such disclosure would violate state or federal privacy laws.

Upon receipt of a Notice of a Final External Review Decision reversing the adverse benefit determination or final internal adverse benefit determination, the Plan immediately must provide coverage or payment (including immediately authorizing or immediately paying benefits) for the *claim*.

Expedited External Review

The Plan must allow you to request an expedited external review at the time you receive:

- An adverse benefit determination, if the adverse benefit determination involves a medical condition for which the time frame for completion of an expedited internal appeal would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function and you have filed a request for an expedited internal appeal; or
- A final internal adverse benefit determination, if you have a medical condition where the time frame for completion of a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, or if the final internal adverse benefit determination concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, but have not been discharged from a facility.

Immediately upon receipt of the request for expedited external review, the *claims administrator* will determine whether the request meets the reviewability requirements set forth above for standard external review. The *claims administrator* must immediately send you a notice of its eligibility determination.

Referral of Expedited Review to ERO

Upon a determination that a request is eligible for external review following preliminary review, the *claims administrator* will assign an ERO. The ERO will render a decision as expeditiously as your medical condition or circumstances require, but in no event more than 72 hours after the ERO receives the request for an expedited external review. If the notice is not in writing, within 48 hours after the date of providing that notice, the assigned ERO must provide written confirmation of the decision to you, the *claims administrator*, and the Plan.

Eligibility Issue Appeals

There are three levels of appeal available if you receive an adverse benefit decision and you need to file an *eligibility issue* appeal.

- **Level 1 Appeals:** Submit your *eligibility issue* appeal directly to Claims and Appeals Management (CAM) within 180 days from the date of your receipt of an adverse benefit decision. Such appeals must be in writing on the appropriate Appeal Initiation Form. You can obtain an Appeal Initiation Form by contacting the Your Benefits Resources Customer Service Center at **1-866-520-3280**. Submit your *eligibility issue* appeal—along with any supporting comments, documents, records, and other information—by first-class mail postage paid, to:

  Claims and Appeals Management (CAM)
  P.O. Box 1407
  Lincolnshire, IL 60069-1407
  1-866-520-3280
- **Level 2 Appeals:** If your initial *eligibility issue* appeal is denied, you can request a review of the denied *eligibility issue* appeal. Submit your request for review of a denied *eligibility issue* appeal to the Employee Benefits Department. You must file your request for review of the denied *eligibility issue* appeal within 180 days after you receive your “Level 1” denial notice. If you fail to file a request for review of a denied *eligibility issue* appeal within the 180-day period, it will be considered a failure to exhaust all administrative remedies under the Plan. Submit your request to the Employee Benefits Department at:

  Employee Benefits Department
  2700 Lake Cook Road
  Riverwoods, IL 60015
  1-847-580-5000

- **Level 3 Appeals (Final):** If your “Level 2” eligibility issue appeal is denied, you can request a review of the denied Level 2 eligibility issue appeal. You must file your request for review of the denied eligibility issue appeal within 60 days after you receive your “Level 2” denial notice. If you fail to file a request for review of a denied eligibility issue appeal within the 60-day period, it will be considered a failure to exhaust all administrative remedies under the Plan. Submit your request to the Wolters Kluwer Benefits Administrative Committee at:

  Wolters Kluwer Benefits Administrative Committee
  2700 Lake Cook Road
  Riverwoods, IL 60015
  1-847-580-5000

Process for Filing Eligibility Issue Appeals

Processes are in place for filing initial appeals as well as filing a request for review of a denied appeal.

Initial Appeals

The process to follow for filing an initial *eligibility issue* appeal with CAM depends on the type of appeal:

- **Pre-Service and Post-Service Eligibility Issue Appeals:** A communication from you or your duly authorized representative is considered a valid *eligibility issue* appeal if it's in writing on the appropriate Appeal Initiation Form and delivered—along with any supporting comments, documents, records, and other information—by first-class mail postage paid, to:

  Claims and Appeals Management (CAM)
  P.O. Box 1407
  Lincolnshire, IL 60069-1407

  Contact the Your Benefits Resources Customer Service Center at **1-866-520-3280** to obtain the Appeal Initiation Form.

- **Urgent and Concurrent Care Eligibility Issue Appeals:** In the interest of time, all urgent or concurrent care eligibility issue appeals can be submitted orally by you or your duly authorized representative. To file a concurrent or urgent care eligibility issue appeal with CAM, call the Your Benefits Resources Customer Service Center at **1-866-520-3280** Monday through Friday, 8 a.m. to 8 p.m. Eastern time.

Requests for Review of Denied Appeals

Here's the process to follow if you want to file a request for review of a denied *eligibility issue* appeal.

- Submit “Level 2” requests for review of denied *eligibility issue* appeals to the Employee Benefits Department within 180 days after you receive your denial notice. “Level 3” requests for review should be submitted to the Wolters Kluwer Benefits Administrative Committee within 60 days after you receive your denial. The process to follow for filing a request for review of a denied *eligibility issue* appeal depends on the type of appeal:

- **Review of Denied Pre-Service and Post-Service Eligibility Issue Appeals:** A communication from you is considered a valid request for review of a denied pre-service or post-service *eligibility issue* appeal if it's in writing and delivered—along with any supporting comments, documents, records, and other information—by first-class mail postage paid, to the:

  Level 2
  Employee Benefits Department
  2700 Lake Cook Road
  Riverwoods, IL 60015

  Level 3
  Wolters Kluwer Benefits Administrative Committee
  2700 Lake Cook Road
  Riverwoods, IL 60015
- **Review of Denied Urgent and Concurrent Care Eligibility Issue Appeals:** In the interest of time, all requests for review of denied urgent or concurrent care eligibility issue appeals can be submitted orally to the Employee Benefits Department or the Wolters Kluwer Benefits Administrative Committee. To request a review of a denied concurrent or urgent eligibility issue appeal, call **1-847-580-5000**, Monday through Friday from 8:30 a.m. to 5 p.m. Central time.

Review Procedures Followed to Review a Denied Appeal

If you request a review of a denied *eligibility issue* appeal, CAM and the Wolters Kluwer Benefits Administrative Committee (as applicable) will follow the review procedures as follows.

- A review takes place and considers all comments, documents, records, and other information you submit (without regard to whether such information was submitted or considered in the initial appeal determination).
- You have the opportunity to submit written comments, documents, records, and other information related to the appeal.
- You're provided, upon request and free of charge, reasonable access to and copies of all relevant documents.
- The review of a denial doesn't defer to the initial determination.
- The individual who conducts the review process isn't the individual who made the initial denial, nor the subordinate of such individual.
- Any experts whose advice was obtained on behalf of the Plan in connection with your denial are identified, without regard as to whether the advice was relied upon in making the determination.
- In the case of an appeal involving urgent care, an expedited review process is provided. You may request an expedited appeal orally or in writing, and all necessary information may be transmitted between the Plan and you by telephone, fax, or other available similar expeditious methods.
- The Plan will provide any new or additional evidence considered, relied upon, or generated by the Plan in connection with your *claim*, which will be provided to you as soon as possible to allow you to respond prior to the date that a decision on your appeal is due.
- In the event the Plan issues an adverse benefit determination on review based on a new or additional rationale, the Plan will provide the new or additional rationale to you as soon as possible to allow you to respond prior to the date that a decision on your appeal is due.

LRP Complaints

Should you disagree with a decision made relative to the LRP, you can file your complaint with ComPsych at the following address:

ComPsych Corporation
NBC Tower - 13th Floor
455 North Cityfront Plaza Drive
Chicago, IL 60611
1-312-595-4000

Authority

Benefits under the Plan will be paid only if the Wolters Kluwer Benefits Administrative Committee determines, in its discretion, that you're entitled to them. The Committee's decisions are conclusive and binding.

Legal Action

After exhaustion and completion of all Plan *claim*s and appeals procedures, any lawsuit that involves Plan benefits that's filed against the Plan, the *Company* or its employees, the Plan Administrator, or any Plan fiduciary must be brought within 90 days from the final decision on a *claim* appeal. No action at law or in equity shall be brought to recover benefits under the Plan until the *claim* and appeal rights provided herein have been exercised and exhausted and until requested Plan benefits have been denied in whole or in part.

Coordination of Benefits (COB)

Coordinating Plans

If you or your dependents have coverage under another group health plan, the WKUS Health Plan coordinates with benefits from one or more other sources. This eliminates duplicate payment of benefits for the same service. This is called Coordination of Benefits (COB). When you become eligible for coverage and any time that you submit a request for benefits, you're asked to provide information regarding your other group health coverage(s). If you don't provide this information, the Plan may delay the processing of your benefits request.

Certain types of plans normally coordinate benefits, including the following:

- Plans or coverages provided by an employer, union, trust, association, or other similar sponsor.
- Coverage offered by a group, group *hospital*, or medical service.
- Other group health plans, or coverages that cover you or your dependents, including student coverage provided through a school above the high school level (i.e., a college health plan). In the case of a dependent's school health plan, this Plan may coordinate benefits with the other plan if the school's policy allows benefit coordination. For more information, contact the school.
- Government benefit programs provided or required by law, including *Medicare* or *Medicaid*, and Workers' Compensation.
- Automobile insurance plans in the case of *accidents*; for example, certain kinds of coverage under no-fault car insurance that's required by law.

These coordination provisions don't apply to individual or private insurance plans for which you pay the full cost. In addition, the COB feature doesn't apply in the case of dual coverage under the Plan (i.e., you and your spouse both work for the *Company* and both have coverage under the Plan).

Any benefits to which you may be entitled are considered for possible coordination (even if you don't request payment from them).

How This Plan Coordinates With Other Group Plans

If you're covered by more than one group plan, one plan is primary. The primary plan pays benefits first without considering the other plans. Then—based on what the primary plan pays—the other plans (secondary plans) may pay a benefit (if any), depending on their COB rules.

If your coverage under this Plan is primary, this Plan pays benefits up to the limits described in this SPD.

If your coverage under this Plan is secondary, this Plan pays benefits based on the “maintenance of benefits rule.” This means that this Plan determines what it would have paid if it were the primary plan, and then subtracts out the benefits paid by the actual primary plan. Maintenance of benefits is calculated on an annual basis. As a result, this Plan only pays benefits if the primary plan's year-to-date benefit total is less than the total that would have been paid if this Plan had been the primary plan. If the primary plan's total equals or exceeds the total amount that would have been paid by this Plan as the primary plan, then this Plan doesn't pay any benefits. See “Examples of How the Plan's COB Feature Works” under this main section for additional detail of how coordination works.

Examples of How the Plan's COB Feature Works

To show how the Plan's COB feature works, let's assume that you have primary coverage under the WKUS Health Plan, your covered spouse has secondary coverage under the WKUS Health Plan, your spouse's year-to-date *eligible expenses* total $10,000, and your spouse's plan pays $9,500 of the *eligible expenses* as the primary plan. Here's how the WKUS Health Plan coordinates benefits as the secondary coverage for your spouse.

Example #1

Year-to-Date Eligible Expenses:	$10,000
Amount Payable if the WKUS Health Plan Were Primary:	$9,250
Amount Payable by the Primary Plan:	$9,500
Amount Payable by the WKUS Health Plan (Secondary Coverage):	$0

Since the primary plan pays $9,500 and the WKUS Health Plan would only pay $9,250 if it were the primary plan, the WKUS Health Plan doesn't pay any more benefits as the secondary coverage.

Now let's assume that your spouse's plan (still the primary plan) pays $9,000. Here's how the WKUS Health Plan coordinates benefits as the secondary coverage for your spouse.

Example #2

Year-to-Date Eligible Expenses:	$10,000
Amount Payable if the WKUS Health Plan Were Primary:	$9,250
Amount Payable by the Primary Plan:	$9,000
Amount Payable by the WKUS Health Plan (Secondary Coverage):	$250

Since the primary plan only pays $9,000 of the $10,000 *eligible expense* and the WKUS Health Plan would have paid $9,250 if it were the primary plan, the WKUS Health Plan pays $250 of the *eligible expense*.

Deciding in which plan to enroll your spouse and children is something to consider based on each plan's benefits and coverage cost. It's not necessarily advantageous to enroll in the WKUS Health Plan if the other plan is primary.

Determining the Order of Payment

When benefits coordinate, the plans or coverages involved determine which pays benefits first (the primary), second (the secondary), etc. The Plan follows these guidelines when determining which is primary:

- If one plan has no COB provision, it automatically is primary.
- The plan covering the person as the employee rather than as a dependent, laid-off employee, terminated employee, *COBRA* beneficiary, or retired employee is primary and pays benefits (for *eligible expenses*) before a plan that covers the person as a dependent.
- If both parents' plans cover a dependent, this Plan uses the “birthday rule” to determine which parent's plan pays first. The plan of the parent whose birthday comes earlier in the calendar year is the primary plan, and the other parent's plan is secondary. If the other plan doesn't follow the birthday rule, then the rules of that plan determine the order of benefits.
- In the case of a divorce or separation, here's the order of payment.
    - If there's a court decree that states that the parents shall share joint custody of a dependent child, without stating that one of the parents is responsible for the health care expenses of that child, the order of benefit determination rules specified above apply.
    - If there's a court decree that makes one parent financially responsible for the medical, dental, or other health care expenses of such child, the benefits of a plan that covers the child as a dependent of such parent are determined before the benefits of any other plan that covers the child as a dependent child.
    - If there's no such court decree and:
        - The parent with custody of the child **has not** remarried, the benefits of a plan that covers the child as a dependent of the parent with custody of the child are determined before the benefits of a plan that covers the child as a dependent of the parent without custody.
        - The parent with custody of the child **has** remarried, the benefits of a plan that covers the child as a dependent of the parent with custody are determined before the benefits of a plan that covers the child as a dependent of the stepparent. The benefits of a plan that covers the child as a dependent of the stepparent are determined before the benefits of a plan that covers the child as a dependent of the parent without custody.
    - If none of the above applies, the plan that has covered the person longer is usually the primary plan.

How Coordination Works With Medicare

Under current law, you and your dependents become eligible for *Medicare* at age 65. (If you become disabled, you may become eligible for *Medicare* before age 65.)

Please contact the Your Benefits Resources Customer Service Center if you start *Medicare* benefits on account of age or disability. The way the WKUS Health Plan coordinates with *Medicare* depends on your age and whether you're an active or inactive (disabled or retired) employee.

If You're an Active Employee

If you're an active employee or covered by another active employer plan, and you or your spouse becomes *Medicare*-eligible, you or your spouse may have either of the following:

- Medical coverage under this Plan and *Medicare* (the WKUS Plan is primary, it pays benefits as described here, and *Medicare* is secondary); or
- Coverage under *Medicare* only.

You may decline coverage under this Plan and elect *Medicare* as your primary coverage. However, in this case, by law, the WKUS Health Plan can't pay benefits secondary to *Medicare*.

You and your spouse continue to be covered under this Plan as primary unless you notify the *Company* that you don't want coverage under this Plan or you otherwise cease to be eligible for coverage. Your spouse, if age 65 or older, may make a *Medicare* election separate from yours. Your spouse, however, may not elect coverage under this Plan if you don't elect coverage.

Please note: If you or your covered dependent becomes entitled to *Medicare* due to end-stage renal disease, the WKUS Health Plan continues to pay as primary during the first 30 months of dialysis or the first 30 months of treatment in connection with a kidney transplant. Thereafter, *Medicare* generally becomes the primary payor of benefits. Contact your local Social Security Administration office to get more information about enrolling in *Medicare*.

If You're an Inactive Employee (Disabled or Retired)

Coverage is sometimes continued even if you're an inactive employee (i.e., you become disabled or you retire). If you're an inactive employee, here's what happens.

- **Disabled:** If you become disabled and are *Medicare*-eligible, the Plan generally is the primary plan if you receive disability benefits for up to six months, then *Medicare* is generally the primary plan (regardless of your or your covered spouse's age). Please see “Instances When Coverage May Continue” in the “How Long Coverage Continues” section for more information on continued coverage in the event you become disabled.
- **Retired:** If you retire and are age 65 or older, *Medicare* is generally the primary plan. Please see the SPD for the WKUS Retiree Health Plan for detailed information regarding how the WKUS Retiree Health Plan coordinates with *Medicare*.

As an inactive employee, you're responsible for contacting the Your Benefits Resources Customer Service Center if you or your spouse becomes *Medicare*-eligible.

How Coordination Works With Medicaid

The Plan pays benefits in accordance with any assignment of rights made by the participant or on the participant's behalf as required by *Medicaid*. When you enroll in the Plan or the Plan makes benefit payments, it doesn't take into account the fact that you're eligible for or covered under *Medicaid*. If the Plan has a legal liability to pay benefits for items or services covered by *Medicaid*, the Plan pays benefits in accordance with any state law that provides that the state has acquired the rights with respect to the individual for payment of such items or services.

How Coordination Works With Workers' Compensation

Workers' Compensation insurance generally covers medical expenses associated with an:

- On-the-job *accident*; or
- *Illness* that arises out of an occupation.

The Plan excludes coverage for such occupational *accidents* or *injuries*. This applies for your employment with the *Company* and any outside part-time work. It also applies for any of your dependents who may work on a full- or part-time basis.

If you're injured on the job, be sure to report the *accident* to your manager or supervisor immediately. He or she can then direct you to the individual in charge of handling medical bills related to Workers' Compensation, and can activate your Workers' Compensation insurance immediately.

If you're hospitalized for a work-related *accident* or *illness*, be sure to notify your manager or supervisor immediately. He or she can then direct you to the individual who handles Workers' Compensation for WKUS. You'll also want to notify the *hospital* that Workers' Compensation will handle your medical expenses. Please don't submit any bills covered by Workers' Compensation through this Plan.

How Coordination Works With Third-Party Reimbursement

This Plan requires you to reimburse it for any benefits you may receive from a third party that's also responsible for paying benefits for your medical expense. This also is sometimes referred to as subrogation. Please see “Subrogation and Right of Recovery Provisions” under the “Administrative Information” main section for details regarding how the Plan manages benefits in such situations.

How Long Coverage Continues

Overview

Generally, your coverage under the Plan continues while you're still employed by the *Company*. This section highlights when coverage ends, as well as certain instances when coverage for you and your eligible dependents may continue.

When Coverage Ends

Coverage for you and/or your dependents ends on the last day of the month in which the first of the following occurs, unless otherwise noted:

- You no longer meet the Plan's definition of an eligible employee (see the “Eligibility” main section for details);
- Your dependent no longer meets the Plan's definition of an eligible dependent (see the “Eligibility” main section for details);
- Your *domestic partner* no longer meets the Plan's definition of an eligible dependent due to the Plan no longer allowing such coverage, or because the partnership ends;
- You stop making the required contribution for coverage;
- You and/or your dependent elects to terminate coverage under the Plan;
- The Plan is terminated; or
- The *Company* for which you work no longer participates in the Plan (see “Whom the Plan Pertains To” under the “Administrative Information” main section for details regarding participating organizations).

If you retire and are eligible for retiree medical coverage under the WKUS Retiree Health Plan, coverage under this Plan ends at the end of the month in which you retire. Coverage under the WKUS Retiree Health Plan begins the first of the month following the day you retire.

Even though coverage under the Plan terminates if one of the events listed above occurs, coverage can be extended in certain circumstances. See “Instances When Coverage May Continue” under this main section for details.

Certificates of Creditable Coverage

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) makes it easier for people changing jobs to be eligible for health plan coverage without being subject to a *pre-existing condition* exclusion under a new employer's medical plan.

If your coverage under this Plan ends, you can request a *certificate of creditable coverage* of group health plan coverage from your claims administrator. The certificate provides written confirmation of the length and type of medical coverage you had under this Plan. You may then take this certificate to another health care plan and reduce or eliminate any *pre-existing condition* exclusion that may apply under the new employer's plan or insurance policy. (You only need to do this if the other health care plan has a *pre-existing condition* limitation.)

Instances When Coverage May Continue

In certain instances, coverage may continue for you and your covered dependents even though you no longer meet the Plan's eligibility requirements.

- **If You Die While Employed:** If you die while you're still employed, coverage for your dependents ends on your date of death. Your covered dependents are eligible to continue coverage under *COBRA*. See the “Continuation Rights Under COBRA” main section for details.

- **If You Become Totally and Permanently Disabled (Long-Term Disability [LTD]):** If you meet the definition of disability under the WKUS Long-Term Disability Plan (regardless of whether you elected coverage under that Plan), coverage for you and/or your eligible dependents may continue through the *COBRA* continuation period, or until you’re no longer disabled, whichever is earlier.

  See the “Continuation Rights Under COBRA” main section for details.

  While covered by the Plan, if you or covered family member becomes eligible for *Medicare*, contact Your Benefits Resources.

  If you meet the eligibility, enrollment, and contribution requirements under the WKUS Retiree Health Plan at the time you become eligible to receive LTD benefits, you're eligible to participate in the WKUS Retiree Health Plan on the first day of the month following (or coinciding with) the day you become totally disabled. However, to the extent that you and/or your eligible dependents become eligible for *Medicare* as a result of your total disability, coverage under the WKUS Retiree Health Plan will be ‘secondary” to the coverage provided by *Medicare*. See the separate SPD for the WKUS Retiree Health Plan for details.

  If you recover and return to work at Wolters Kluwer, you will have the opportunity to re-enroll in the Active Medical Plan.

  Please note: Special rules apply if you're an employee of CCH Incorporated, you're disabled, you have 10 or more *years of service*, and you were covered by the CCH Health Plan on December 31, 1997. Contact Your Benefits Resources for more information if these special rules apply to you.

- **If You Take an Approved Leave of Absence (Non-FMLA):** You may decide to take an approved leave of absence either with or without pay. If you do and you continue to meet the Plan's definition of an eligible employee, you're able to continue your coverage under the Plan on the same basis as when you were *actively at work*. You will be billed for coverage on an after-tax basis through Your Benefits Resources.

- **If You Take an Approved Leave of Absence (FMLA):** If you decide to take an **unpaid** approved leave of absence under the Family and Medical Leave Act of 1993 (FMLA), you can continue coverage for you and your eligible dependents during your period of FMLA leave as if you were still *actively at work*. You will be billed for coverage, and you must continue to submit payment for your coverage. Continued coverage ends once you:
    - Terminate employment;
    - Fail to make any contributions for coverage; or
    - Don't return from your FMLA leave.

  If your employment doesn't terminate during your leave, but you don't return to work once your leave ends, you can elect to continue coverage under *COBRA*. Your *COBRA* continuation period begins on the day after your last day of your FMLA leave.

  If you don't return to work after your leave, the *Company* may recover the value of benefits or contributions paid to maintain your coverage during your FMLA period of leave. (This doesn't apply if your failure to return to work is due to a continuation, recurrence, or onset of a *serious health condition* that affects you or a family member and for which you would normally qualify for a leave under the FMLA).

  In addition, in compliance with the National Defense Authorization Act of 2008, if you're an eligible employee, you can take up to 12 combined weeks of FMLA leave in a single 12-month period for a qualifying exigency to spend time with a spouse, son, daughter, or parent on active duty or notified of call to duty.

  Also, if you're an eligible employee caring for a spouse, child, parent, or next of kin who's a recovering service member, meaning he or she has suffered a serious *illness* or *injury* sustained in the line of duty on active duty, or if you're an eligible employee caring for a veteran who's undergoing medical treatment, recuperation, or therapy for a serious *illness* or *injury* incurred in the line of active duty (if the treatment, recuperation, or therapy is occurring within five years of the veteran's military service), you can take up to 26 combined weeks of FMLA leave in a single 12-month period to care for the service member. The military caregiver leave described above doesn't limit the availability of FMLA leave for other purposes during any other 12-month period.

- **If You Take an Approved Leave of Absence for Uniformed Service (Continuation of Health Coverage Under the Uniformed Services Employment and Reemployment Rights Act of 1994 [USERRA]):** If you're absent from work because of your service in the *uniformed services* (including Reserve and National Guard duty), you may elect to continue health coverage for yourself and your eligible dependents under the provisions of USERRA. The period of coverage for you and your eligible dependents ends on the earlier of:
    - The end of the 24-month period starting on the day your military leave of absence begins.

- The day after the day on which you're required but fail to apply for or return to work. Under USERRA, you must apply to return to work within different time periods—depending on the duration of your *uniformed service*:
    - **If your *uniformed service* is less than 31 days:** You're generally required to apply to return to work on the first full calendar day of the first full scheduled work period following your period of *uniformed service*. (Your period of *uniformed service* ends after you return from your place of service to your residence.)
    - **If your *uniformed service* is between 31 and 180 days:** You're generally required to apply to return to work within 14 days of your discharge.
    - **If your *uniformed service* is at least 181 days:** You're generally required to apply to return to work within 90 days of your discharge.

Your right to continue coverage under USERRA will run concurrently with your right to *COBRA* continuation coverage. See the “Continuation Rights Under COBRA” main section for more details. Please contact a Your Benefits Resources Customer Service Representative to confirm whether you're required to pay all or a portion of the cost of your coverage while you're absent due to *uniformed service*s duty.

You also must notify your supervisor that you'll be absent from employment due to military service (unless you can't give notice because of military necessity or unless under all relevant circumstances, notice is impossible or unreasonable). You also must notify Your Benefits Resources that you want to elect continuation coverage for yourself and/or your eligible dependents under the USERRA provisions.

Continuation Rights Under COBRA

What's COBRA

A federal law known as the *Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (COBRA)*, requires most employers, including Wolters Kluwer, that sponsor medical benefit plans (including HMOs) to offer employees and eligible members of their families the opportunity to extend coverage temporarily at group rates after coverage under the Plan would otherwise end. The Plan also offers covered *domestic partners* (and the covered children of *domestic partners*) continuation coverage rights that are equivalent to those offered under *COBRA* to the covered spouses and covered dependent children of employees, as described here. The extension of coverage to employees and their eligible dependents is called “continuation coverage.”

This section highlights continuation coverage under *COBRA*. Alight is the *COBRA* administrator. Therefore, be sure to contact the Your Benefits Resources Customer Service Center for any *COBRA*-related transactions.

In general, the coverage that may be continued is the same as the coverage in which you and your eligible dependents were enrolled under the Plan as an active employee on the day before you experienced the qualifying event. If you or your eligible dependents weren't enrolled in the Plan as an active employee immediately prior to experiencing a qualifying event, then you aren't eligible for any continuation coverage.

You may have other options available to you when you lose medical coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. In addition, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse’s plan), even if that plan generally doesn’t accept late enrollees. For additional information about the Health Insurance Marketplace, visit **www.healthcare.gov**.

Qualifying Events and Maximum COBRA Periods

To be eligible for continuation coverage, a qualifying event must take place and as a result, you must lose coverage. After the qualifying event, continuation coverage must be offered to each person who is a qualified beneficiary. See “Who Is a Qualified Beneficiary” under this main section for details.

The “A Snapshot of Continuation Coverage” chart below lists the continuation choices available to qualified beneficiaries under *COBRA*, based on specific qualifying events that would otherwise result in a loss of coverage. Qualified beneficiaries must elect coverage under this Plan at the time of the qualifying event to be eligible for continuation coverage. You may also elect *COBRA* coverage for an eligible child who's born, adopted, or placed with you for adoption while your *COBRA* coverage is in effect.

“Important Notes” and “About the Disability Extension” under this subsection also contain important details regarding qualifying events and *COBRA* periods.

A Snapshot of Continuation Coverage

The chart below lists the qualifying events and the continuation choices available to qualified beneficiaries under *COBRA*.

Qualifying Event	Maximum Continuation Coverage Period*
▪ Termination of your employment (other than for gross misconduct) ▪ Reduction in your hours of employment that would cause you to lose eligibility ▪ Retirement	You and your covered dependents have the right to continue medical coverage for up to 18 months.
▪ Your death ▪ Divorce or legal separation between you and your spouse (unless a Qualified Medical Child Support Order provides otherwise) ▪ Termination of your relationship with your domestic partner ▪ Your child or the child of your domestic partner no longer meets the definition of a dependent under the Plan ▪ You become entitled to Medicare (under Part A, Part B, or both)**	Your covered dependents have the right to continue medical coverage for up to 36 months.
▪ You or your covered dependents are determined to be disabled under Title II or XVI of the Social Security Act	The initial 18-month period of continuation coverage may be extended for medical coverage for up to 11 months (for a total of up to 29 months of continuation coverage). See “About the Disability Extension” under this subsection for details.

A child who is born, adopted, or placed with you for adoption during a period of continuation coverage may be added to the coverage. As long as you notify Your Benefits Resources within the 31-day period, coverage begins as of the date of birth, adoption, or placement for adoption. The child will have all of the continuation coverage rights that any other covered dependent otherwise would have.

* The duration of coverage is from the first date you are eligible for *COBRA*.
** The 36-month coverage begins on the day you enroll in *Medicare*.

Important Notes

If a second qualifying event (that isn't termination of employment or reduction in your hours of employment) occurs within the 18- or 29-month period, the *COBRA* continuation period for medical coverage may be extended for up to 36 months from the first qualifying event. Notify Your Benefits Resources within 31 days if a second qualifying event occurs during a continuation coverage period.

A qualified beneficiary doesn't have to show that he or she is insurable to choose continuation coverage. However, continuation coverage under the law is provided subject to eligibility for coverage under the Plan. The Plan reserves the right to terminate a qualified beneficiary's continuation of coverage retroactively if such qualified beneficiary is determined to be ineligible.

HMO coverage options are also subject to state continuation of coverage requirements. Some states, like California, provide continuation of coverage rights that are more favorable than those described in this summary. This means that you could be entitled to additional continuation coverage if you're a resident of such state and enrolled in an HMO coverage option. For further information, contact the HMO offered in your area.

About the Disability Extension

The Social Security Administration (SSA) may determine that you were disabled at any time within 60 days of the qualifying event (i.e., the disability began at some time before the 60th day of continuation coverage and must continue at least until the end of the 18-month continuation coverage period). The 11-month extension applies to all disabled and non-disabled qualified beneficiaries entitled to continuation coverage as a result of the same qualifying event to which the disability extension applies, subject to the notice requirements (see “Reporting a Qualifying Event” under this main section for details).

You must notify Your Benefits Resources about the SSA's determination within 60 days of receiving it and prior to the end of the initial 18-month continuation coverage period to receive extended coverage. Monthly contributions for continuation coverage increase to 150% (from 102%) of the monthly amount for each of the 11 additional months of continuation coverage. If the SSA determines that the individual is no longer *totally disabled*, continuation coverage ends. The qualified beneficiary with respect to the qualifying event to which the disability extension relates must notify Your Benefits Resources within 30 days after the determination. Continuation coverage ends on the first day of the month that's 31 or more days after the SSA's determination that the disability has ended.

Who Is a Qualified Beneficiary

The following could become qualified beneficiaries if coverage under the Plan is lost because of a qualifying event:

- You;
- Your covered spouse;
- Your covered *domestic partner*;
- Your covered dependent child(ren); or
- Your *domestic partner's* covered child(ren).

Reporting a Qualifying Event

You must notify Your Benefits Resources by phone or in writing within 60 days of the date on which any of the following qualifying events occurs and results in your and/or a covered dependent's loss of coverage unless otherwise noted:

- You and your spouse divorce or become legally separated, or your *domestic partnership* ends;
- Your child or the child of your *domestic partner* no longer meets the definition of an eligible dependent under the Plan (see the “Eligibility” main section for details);
- Your *domestic partner* no longer meets the definition of an eligible dependent under the Plan; or
- You (or your covered dependent) are determined to have been disabled under the Social Security Act at any time during the first 60 days of receiving continuation coverage.

To report a qualifying event, contact the Your Benefits Resources Customer Service Center at **1-866-520-3280**.

Your Benefits Resources is automatically notified by the *Company* within 30 days of when any of the following qualifying events occurs:

- Your employment hours are reduced and, as a result, you become ineligible for coverage;
- Your employment terminates;
- You become entitled to *Medicare*; *or*
- You die.

Deciding Whether or Not to Elect Continuation Coverage

As noted above, Your Benefits Resources is typically notified within 30 days by the *Company*, or within 60 days by you, depending upon the qualifying event. You then receive a notice and an enrollment worksheet from Your Benefits Resources within 14 days of the date Your Benefits Resources receives notification of the qualifying event. You must enroll for *COBRA* coverage either online via Your Benefits Resources or through the Your Benefits Resources Customer Service Center within 60 days of the later of the day:

- Coverage ended because of one of the qualifying events described here; or
- The notice of your and your qualified beneficiary's right to elect continuation coverage is sent to you by Your Benefits Resources.

Each qualified beneficiary has an independent right to elect continuation coverage. Covered employees may elect *COBRA* on behalf of their spouse/*domestic partner*, and if you're a parent, you may elect *COBRA* on behalf of your children.

If you and/or your qualified beneficiary or family members don't elect continuation coverage within the 60-day period, or your initial payment isn't timely received as described below, your and/or your qualified beneficiary's and/or family member's coverage under the Plan ends.

Your right to continue *COBRA* coverage is subject to all applicable federal laws and regulations. If you have any questions regarding *COBRA*, contact Your Benefits Resources.

Payment

To continue your coverage, you and/or your covered dependents must pay the full cost of coverage, plus a 2% fee for administrative costs (or a 50% administrative fee in the case of an 11-month extension due to disability). You make this payment during the 18- or 36-month period of continuation coverage.

Your first payment (due within 45 days of your election) must include your *COBRA* contribution for the entire period from the first date you are eligible for *COBRA* through the month of the payment. Invoices will be generated around the 10th of the month and you will be able to submit your first payment after the invoice is created. If payment isn't made within the 45-day period, you'll be deemed to have declined continuation coverage, even if you made elections. Note that coverage is not reinstated until payment has been received. Subsequent contributions are due on the first of the month, whether or not you receive a bill. If Your Benefits Resources doesn't receive your monthly contribution within 30 days of the due date, continuation coverage is canceled as of the last day of the month in which you paid a contribution.

If you don't want to elect continuation coverage, notify Your Benefits Resources. Coverage under the Plan ends on the day the qualifying event occurs.

When Continuation Coverage Ends

A qualified beneficiary's continuation coverage continues until the earliest of:

- The end of the applicable 18-month, 29-month, or 36-month continuation coverage period;
- The day a qualified beneficiary fails to pay the required monthly contribution within the 30-day due-date period;
- The day a qualified beneficiary first becomes covered after the date of his or her continuation coverage election under another group medical plan;
- The day a qualified beneficiary first becomes entitled to *Medicare* after the date of his or her continuation coverage election;
- The day that there has been a final determination by the Social Security Administration that the qualified beneficiary who elected to extend coverage for up to 29 months due to a disability is no longer disabled;
- The day a qualified beneficiary requests (in writing) to cancel coverage; or
- The day the *Company* ceases to provide any group medical coverage.

Administrative Information

Administrative Details

The Plan is governed by ERISA (the Employee Retirement Income Security Act of 1974). This main section provides important legal and administrative information you may need regarding the Plan. The following chart highlights the administrative details for the Plan and each of the coverage options.

Plan	Plan Type	Plan Number	Claims Administrator Insurer (File Claims Here Where Appropriate)	Type of Insurance	Group Number	Contribution
Wolters Kluwer United States Inc. Health Plan	Health	501				
Enhanced HSA			Blue Cross Blue Shield of Illinois Claim Review Section P.O. Box 2401 Chicago, IL 60690 **1-877-238-5944** **www.bcbsil.com**	Self-Insured	759644	Employee and Employer
Core HSA			Blue Cross Blue Shield of Illinois Claim Review Section P.O. Box 2401 Chicago, IL 60690 **1-877-238-5944** **www.bcbsil.com**	Self-Insured	230956	Employee and Employer
PPO Plan			Blue Cross Blue Shield of Illinois Claim Review Section P.O. Box 2401 Chicago, IL 60690 **1-877-238-5944** **www.bcbsil.com**	Self-Insured	759645	Employee and Employer
HMO—Blue Cross Blue Shield HMO Illinois			Blue Cross Blue Shield P.O. Box 805107 Chicago, IL 60680-4112 **1-800-892-2803** **www.bcbsil.com**	Fully Insured*	H98673	Employee and Employer

* The *claims administrator* performs most of the functions that are generally done by insurers in fully insured arrangements, including the payment of *claims* as well as contractual and legal obligations.

Plan	Plan Type	Plan Number	Claims Administrator Insurer (File Claims Here Where Appropriate)	Type of Insurance	Group Number	Contribution
HMO—Blue Advantage			Blue Cross Blue Shield P.O. Box 805107 Chicago, IL 60680-4112 **1-800-892-2803** **www.bcbsil.com**	Fully Insured*	B98673	Employee and Employer
HMO—Kaiser Permanente HMO			Kaiser Permanente **1-800-464-4000** **www.kaiserpermanente.org**	Fully Insured*	S. CA. 102771 N. CA 600870	Employee and Employer
Prescription Drug Coverage—All Blue Cross Blue Shield National Coverage Options	Health	501	CVS Caremark P.O. Box 52136 Phoenix, Arizona 85072-2136 **1-866-586-4797** **www.caremark.com**	Self-Insured	N/A	Employee and Employer
Wolters Kluwer United States Inc. Life Resources Program—All Coverage Options	Welfare	501	ComPsych Corporation NBC Tower - 13th Floor 455 North Cityfront Plaza Drive Chicago, IL 60611 **1-312-595-4000**	Self-Insured	N/A	Employer

Formal Plan Name

When dealing with or referring to the Plan (i.e., in the event of a benefit request, an appeal, or other correspondence), you'll receive a more rapid response if you identify the Plan and Plan coverage option fully and accurately.

The official name of the Plan is the Wolters Kluwer United States Inc. Health Plan (the “Plan”).
The Wolters Kluwer United States Inc. Life Resources Program is known as the ”LRP.” Both the Plan and the LRP are components of the Wolters Kluwer United States Inc. Group Health & Welfare Benefits Plan (the “WKUS Group Plan”).

Plan Type

The Plan is a “welfare benefit plan” under Section 3(1) of the Employee Retirement Income Security Act of 1974 and Sections 105 and 106 of the *Code*, designed to offer eligible employees and their eligible dependents medical coverage.

Employer Identification Number (EIN)

This is the number that the Internal Revenue Service (IRS) assigns to Wolters Kluwer United States Inc. The number is:

13-3577870

Plan Year

The *Plan Year* for recordkeeping and accounting purposes is January 1 through December 31.

The Plan Sponsor

The Plan Sponsor is:

Wolters Kluwer United States Inc.
2700 Lake Cook Road
Riverwoods, IL 60015
1-847-580-5000

The Plan Administrator

The Plan Administrator is:

Wolters Kluwer Benefits Administrative Committee
Wolters Kluwer United States Inc.
2700 Lake Cook Road
Riverwoods, IL 60015
1-847-580-5000

The Wolters Kluwer Benefits Administrative Committee administers the Plan and the Plan coverage options and has full power to control and manage all aspects of the Plan and the Plan coverage options according to its terms and all applicable laws. The Plan Administrator may allocate or delegate its responsibilities for administering the Plan to others and employ others to carry out or give advice with respect to its responsibilities under the Plan. Even though the Wolters Kluwer Benefits Administrative Committee is the Plan Administrator, the Committee retains contracts with the *claims administrators* to assist in the day-to-day operations of the Plan. See “About the Claims Administrators” under this main section for details.

The Plan Administrator files an annual return/report (Form 5500) with the Internal Revenue Service (IRS) for the Plan since it's subject to such reporting requirement. The IRS makes Form 5500 available to the U.S. Department of Labor, which in turn makes the form available for public inspection. As a Plan participant, you have access to a summary of the annual return/report containing certain information found in the full annual return/report. You also may request from the Plan Administrator a copy of the complete annual return/report (Form 5500).

Agent for Service of Legal Process

The agent for service of legal process on the Plan is:

General Counsel
Wolters Kluwer United States Inc.
2700 Lake Cook Road
Riverwoods, IL 60015
1-847-580-5000

A notice for service of legal process may also be served upon the Plan Administrator.

Source of Contributions and Funding Medium

The LRP is funded by employer contributions through general assets of the *Company*.

The WKUS Health Plan's benefits are funded by a combination of employer and employee contributions through the general assets of the *Company*. This means that if you elect to participate in the Plan, the *Company* pays a portion of the amount that's needed to pay for
Plan benefits, and you pay the rest. The amount you pay depends on:

- The cost of providing all benefits under the Plan; and
- The amount the *Company* determines should be paid by employees.

Except for the HMO coverage options, benefits aren't guaranteed by any insurance policy with the *claims administrators*. See “About the Claims Administrators” under this main section.

About the Claims Administrators

ComPsych provides certain administrative services to the LRP. If you have questions about the LRP, you can contact the *claims administrator* at the following:

ComPsych Corporation
NBC Tower - 13th Floor
455 North Cityfront Plaza Drive
Chicago, IL 60611
1-312-595-4000

Blue Cross Blue Shield and CVS Caremark provide certain administrative services to the Plan including the Prescription Drug Program, such as *claims* processing. If you have questions about the Plan, you can contact the *claims administrators* at the following:

Blue Cross Blue Shield of Illinois
P.O. Box 805107
Chicago, IL 60680-4112
1-877-238-5944
www.bcbsil.com

CVS Caremark
P.O. Box 52136
Phoenix, Arizona 85072-2136
1-866-586-4797
www.caremark.com

Benefits under this Plan will be paid if the *claims administrator* decides, in its sole discretion, that the applicant is entitled to them. However, in certain cases, the Plan Administrator makes the final determination in the event of a *claims* appeal. Even though Blue Cross Blue Shield helps to administer the Plan, Blue Cross Blue Shield isn't the Plan Administrator. The Wolters Kluwer Benefits Administrative Committee is the Plan Administrator. See "The Plan Administrator" under this main section for details.

Whom the Plan Pertains To

The Plan, including the information contained here, pertains to eligible groups of employees that have adopted the Plan. As of January 1, 2019, the following is the list of eligible groups:

- Business Filings Incorporated
- C-T Corporation System
- CCH Incorporated
- CCH Legal Information Services, Inc.
- Emmi Solutions, LLC
- Enablon North America Corp.
- Firecracker Inc.
- Health Language, Inc.
- LDI Operations, LLC
- National Registered Agents, Inc.
- Ovid Technologies, Inc.
- Pharmacy OneSource, Inc.
- Refunds Today, LLC
- Tagetik North America LLC
- The Corporation Trust Company
- Universal Tax Systems, Inc.

- UpToDate, Inc
- Wolters Kluwer Clinical Drug Information, Inc.
- Wolters Kluwer ELM Solutions, Inc.
- Wolters Kluwer Financial Services, Inc.
- Wolters Kluwer Financial Services U.S., Inc.
- Wolters Kluwer Health, Inc.
- Wolters Kluwer R&D U.S. LP
- Wolters Kluwer United States Inc.

Any other subsidiary of Wolters Kluwer United States Inc. may also participate in the Plan with approval from Wolters Kluwer United States Inc. You may examine or receive from the Plan Administrator, upon written request, information as to whether a particular entity is a participating *Company* in the Plan, and if so, that organization's address or a complete list of *Companies* that have adopted the Plan.

If the Plan Changes or Ends

The *Company* intends to continue the Plan indefinitely. However, it's impossible to know what will happen in the future. Therefore, the *Company* reserves the right to—at any time and for any reason—change or discontinue or partially terminate the Plan, change or discontinue any benefit provided under the Plan, or increase or decrease contributions under the Plan at its sole discretion. Such a change or discontinuation may be caused by a variety of reasons. If such a change takes place, you'll be notified. No amendment, termination, or partial termination of the Plan will affect *claims* incurred for which items or services have been provided prior to the date of the amendment, termination, or partial termination.

No consent by any participant(s) or any third party shall be necessary for the *Company* to amend or terminate the Plan. Any such amendment or termination may be made by proper action of the Plan Administrator or the Board of Directors of the *Company* (or the Board's authorized delegate), as required by the Plan document. Alternatively, in certain instances, the Plan Administrator (or its authorized delegate) may amend the Plan through an appropriate written instrument.

Representation Contrary to the Terms of the Plan

No employee, officer, or director of the *Company*, the *claims administrators*, or any other company or entity has the authority to alter, vary, or modify the terms of the Plan except by means of an authorized written amendment to the Plan prepared and signed by the Plan Administrator or Board of Directors (or their authorized delegate), as appropriate. No verbal or written representations contrary to the terms of the Plan, or its written amendments, shall be binding upon the Plan, the Plan Administrator, or the *Company*.

Subrogation and Right of Recovery Provisions

Here is some important information regarding the subrogation and right of recovery provisions.

Definitions

As used throughout this provision, here are definitions for the following terms.

- **Responsible Party:** Any party that is actually, possibly, or potentially responsible for making any payment to a covered person due to a covered person's *injury*, *illness*, or condition. This term includes the liability insurer of such party or any insurance coverage.
- **Insurance Coverage:** Any coverage that provides expense coverage or liability coverage, including (but not limited to) uninsured motorist coverage, underinsured motorist coverage, personal umbrella coverage, medical or dental payments coverage, Workers' Compensation coverage, no-fault automobile insurance coverage, or any first-party insurance coverage.
- **Covered Person:** Anyone on whose behalf the Plan pays or provides any benefit, including (but not limited to) the minor child or dependent of any Plan participant or person who is entitled to receive any Plan benefits.

Subrogation

Immediately upon paying or providing any benefit under this Plan, the Plan shall be subrogated to (stand in the place of) all rights of recovery a covered person has against any responsible party with respect to any payment made by the responsible party to a covered person due to a covered person's *injury*, *illness*, or condition to the full extent of benefits provided or to be provided by the Plan.

Reimbursement

If a covered person receives any payment from any responsible party or insurance coverage as a result of an *injury*, *illness*, or condition, the Plan has the right to recover from, and be reimbursed by, the covered person for all amounts this Plan has paid and will pay as a result of that *injury*, *illness*, or condition, from such payment, up to and including the full amount the covered person receives from any responsible party. If the covered person fails to reimburse the Plan within seven days of receipt of payment from or on behalf of a responsible person or from a third party, the Plan, in its discretion, may impose an interest at the rate of 1 ½% per month on the unreimbursed amount due the Plan.

Constructive Trust

By accepting benefits (whether the payment of such benefits is made to the covered person or made on behalf of the covered person or any *provider*) from the Plan, the covered person agrees that if he or she receives any payment from any responsible party as a result of an *injury*, *illness*, or condition, he or she will serve as a constructive trustee over the funds that constitute such payment. Failure to hold such funds in trust will be deemed a breach of the covered person's fiduciary duty to the Plan.

Lien Rights

Further, the Plan will automatically have a lien to the extent of benefits paid by the Plan for the treatment of the *illness*, *injury*, or condition for which the responsible party is liable. The lien shall be imposed upon any recovery whether by settlement, judgment, or otherwise, including from any insurance coverage, related to treatment for any *illness*, *injury*, or condition for which the Plan paid benefits. The lien may be enforced against any party who possesses funds or proceeds representing the amount of benefits paid by the Plan including (but not limited to):

- The covered person, the covered person's representative, or agent;
- The responsible party;
- The responsible party's insurer, representative, or agent; and/or
- Any other source possessing funds representing the amount of benefits paid by the Plan.

First-Priority Claim

By accepting benefits (whether the payment of such benefits is made to the covered person or made on behalf of the covered person to any *provider*) from the Plan, the covered person acknowledges that this Plan's recovery rights are a first-priority *claim* against all responsible parties and are to be paid to the Plan before any other *claim* for the covered person's damages. This Plan shall be entitled to full reimbursement to the extent of benefits paid by the Plan on a first-dollar basis from any responsible party's payments, even if such payment to the Plan will result in a recovery to the covered person that is insufficient to make the covered person whole or to compensate the covered person in part or in whole for the damages sustained. The Plan isn't required to participate in or pay court costs or attorney fees to any attorney hired by the covered person to pursue the covered person's damage *claim*.

Applicability to All Settlements and Judgments

The terms of this entire subrogation and right of recovery provision shall apply, and the Plan is entitled to full recovery regardless of whether any liability for payment is admitted by any responsible party and regardless of whether the settlement or judgment received by the covered person identifies the benefits the Plan provided or purports to allocate any portion of such settlement or judgment to payment of expenses other than medical or dental expenses. The Plan is entitled to recover from any and all settlements or judgments, even those designated as pain and suffering, non-economic damages, and/or general damages only. Further, the Plan's right to subrogation or reimbursement won't be affected or reduced by the “make whole” doctrine, the “fund” doctrine, the “common fund” doctrine, comparative/contributory negligence, “collateral source” rule, “attorney's fund” doctrine, regulatory diligence, or any other equitable defenses that may affect the Plan's right to subrogation or reimbursement.

Cooperation

The covered person shall fully cooperate with the Plan's efforts to recover its benefits paid. It's the duty of the covered person to notify the Plan within 30 days of the date when any notice is given to any party, including an insurance company or attorney, of the covered person's intention to pursue or investigate a *claim* to recover damages or to obtain compensation due to *injury*, *illness*, or condition sustained by the covered person. The covered person and his or her agents shall provide all information requested by the Plan, the *claims administrator*, or its representatives, including (but not limited to) completing and submitting any applications or other forms or statements as the Plan may reasonably request. Failure to provide this information may result in the termination of benefits for the covered person or the institution of court proceedings against the covered person.

The covered person shall do nothing to prejudice the Plan's subrogation or recovery interest or to prejudice the Plan's ability to enforce the terms of this Plan provision. This includes, but isn't limited to, refraining from making any settlement or recovery that attempts to reduce or exclude the full cost of all benefits provided by the Plan.

The covered person acknowledges that the Plan has the right to conduct an investigation regarding the *injury*, *illness*, or condition to identify any responsible party. The Plan reserves the right to notify the responsible party and his or her agents of its lien. Agents can include, but aren't limited to, insurance companies and attorneys.

Interpretation

In the event that any *claim* is made that any part of this subrogation and right of recovery provision is ambiguous, or questions arise concerning the meaning or intent of any of its terms, the *claims administrator* for the Plan shall have the sole authority and discretion to resolve all disputes regarding the interpretation of this provision.

Jurisdiction

By accepting benefits (regardless of whether payment of such benefits is made to the covered person or made on behalf of the covered person to any *provider*) from the Plan, the covered person agrees that any court proceeding with respect to this provision may be brought in any court of competent jurisdiction as the Plan may elect. By accepting such benefits, the covered person hereby submits to each such jurisdiction, waiving whatever rights may correspond to him or her by reason of his or her present or future domicile.

Overpayments

Whenever the Plan pays benefits in excess of the amount of payment required under the Plan, the Plan Administrator, its delegate(s), or a *claims administrator* will have the right to recover any such excess payments from any person who received the excess payments. The Plan, or its designee, may withhold or offset future benefit payments, sue to recover such amounts, or may use any other lawful remedy to recoup any such amounts.

Release of Health-Related Information (HIPAA Privacy)

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal law that, in part, requires group health plans to protect the privacy and security of your confidential health information. As an employee welfare benefit plan under ERISA, the Plan is subject to the HIPAA privacy rules.

Your protected health information (PHI) is subject to safeguard under the privacy provisions of HIPAA. Under HIPAA, the *Company* has adopted policies that restrict the use and disclosure of your PHI. Generally, use and disclosure of PHI is limited to payment and health care operation functions, and only the “minimum necessary” information may be used or disclosed.

PHI is the information that the Plan creates and obtains in providing benefits to you. PHI includes health information that could identify you. It's created or received by a health care *provider*, health plan, employer, or life insurer, and either relates to the physical or mental health of an individual, the provision of health care to an individual, or the payment for the provision of health care to an individual. PHI can be in an electronic, paper, or oral format.

The *Company* respects the confidentiality of your health information (medical, prescription drug, health screening, etc.). As a participant in the Plan, you're entitled to receive a privacy notice from the *Company* with respect to benefits offered under the Plan. The privacy notice describes your rights under HIPAA, including standards and procedures for the exercise of those rights. The *Company's* privacy notice more fully describes the important uses and disclosures of PHI, the *Company's* compliance procedures and responsibilities, your rights under HIPAA, as well as your rights to view your PHI and make any corrections.

If you have any questions, please do one of the following:

- Call the *claims administrator* or your health care *provider* (i.e., *hospital*, *physician*) for questions about your medical history or *claims*.
- Contact the *Company's* Privacy Officer with questions or concerns about the use of your PHI, or if you would like to receive an additional copy of the *Company's* privacy notice.
- Call the Your Benefits Resources Customer Service Center if you have questions regarding your enrollment or eligibility for the Plan.

If you're covered under a HMO option, you'll also receive a privacy notice from the HMO describing the HMO *provider's* use and disclosure of PHI.

Employment Rights Not Guaranteed

Your Plan participation doesn't guarantee your employment with the *Company*. It also doesn't ensure you rights to reimbursements, except as specified under the Plan's terms. This SPD isn't a contract of employment and it doesn't expand your employment right with the *Company* or any subsidiary or affiliate.

No Vesting

No person shall have any guaranteed or vested right to receive or continue to receive any benefits provided under the Plan.

Limitation on Rights

No participant, beneficiary, or other person shall acquire, by reason of the Plan, this SPD, or any Plan document, any right in or title to any assets, funds, or property of the *Company*. No employee officer, director, or agent of the *Company* guarantees in any manner the payment of Plan benefits.

Assignment

To the extent permitted by law, no benefit payment under this Plan shall be subject in any way to alienation, sale, transfer, assignment, pledge, attachment, garnishment, execution, levy, lien, or encumbrance of any kind, and any attempt to accomplish the same shall be void. The Plan Administrator shall have the right, in its sole discretion, to accept a valid assignment for payment of Plan benefits made by a participant to a company, *physician*, *dentist*, or other *provider*.

Your Duties and Responsibilities

Operating a successful Plan is a cooperative effort. To receive benefits under this Plan, all participants and beneficiaries must cooperate with the reasonable requests of the Plan Administrator or its designated agents in enforcing the Plan's terms. Your responsibilities include such actions as:

- Promptly providing all of the information that the Plan Administrator may request.
- Notifying the Plan Administrator immediately of any changes in that information (including any change of address, name, etc.). You also need to update your personal information with Wolters Kluwer HR Source by calling **1-888-495-4772**.
- Notifying the Plan Administrator of your, or your dependent's, change in status including any that impact eligibility for benefits under the Plan.
- Notifying the Plan Administrator immediately if you feel that any report related to your benefits is inaccurate.
- Giving the Plan Administrator as much advance notice as possible (and no later than the dates stated here) of your intentions.
- Making sure that the Plan Administrator has your current address.
- Notifying the *claims administrator* or the Plan Administrator and providing all information and assistance the *claims administrator* or Plan Administrator requests if your *illness* or *injury*:

    - Was caused by a third party;
    - Occurred at work; or
    - May be covered by another insurance or may be the responsibility of a third party.

Failure to notify the Plan Administrator of these events may result in a loss or reduction of Plan benefits.

Whom to Contact With Questions

Questions?

Coverage Option	Contact Information
Blue Cross Blue Shield National Coverage Options	Blue Cross Blue Shield **1-877-238-5944** **www.bcbsil.com** The Blue Cross Blue Shield 24/7 Nurseline at **1-800-299-0274** Be sure to call Blue Cross Blue Shield Customer Service to satisfy all preauthorization requirements. See “The Managed Care Program” main section for details. Failure to call can result in financial penalties. To review the balance in your Health Savings Account (HSA) any time, go to **www.hsabank.com**.
CVS Caremark Prescription Drug Coverage	CVS Caremark **1-866-586-4797** **www.caremark.com**
HMO Coverage Options	
▪ **Illinois and Greater Chicago Area**	Blue Cross Blue Shield HMO Illinois **1-800-892-2803** **www.bcbsil.com** Blue Advantage **1-800-892-2803** **www.bcbsil.com**
▪ **California**	Kaiser HMO **1-800-464-4000** **www.kaiserpermanente.org**
MDLIVE	MDLIVE Virtual visits (for BCBS National Coverage Options only) **1-888-676-4204** **MDLIVE.com/bcbsil**
WKUS Life Resources Program (LRP)	ComPsych Corporation NBC Tower - 13th Floor 455 North Cityfront Plaza Drive Chicago, IL 60611 **1-312-595-4000**
General Benefit Questions	Your Benefits Resources **www.yourbenefitsresources.com/wolters_kluwer** Your Benefits Resources Customer Service Center **1-866-520-3280**
COBRA	Your Benefits Resources Customer Service Center **1-866-520-3280**

Coverage Option	Contact Information
Health Advocate	**Have you contacted the carrier but still need assistance?** Access Health Advocate at **1-866-695-8622**, or online, **HealthAdvocate.com/members**.

Your ERISA Rights

Receive Information About Your Plan and Benefits

As a participant in the Plan, you're entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974, as amended (ERISA). ERISA provides that all participants of the Plan be entitled to the following.

- Examine (without charge) at the Plan Administrator's office and at other specified locations of the *Company* such as work sites all Plan documents, including copies of all documents filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including copies of the latest annual report (Form 5500 Series), and an updated Summary Plan Description (SPD). The Plan Administrator may make a reasonable charge for the copies.
- Receive summaries of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report. These summaries are posted on the Wolters Kluwer Intranet site each year.

Continue Group Health Plan Coverage

- Under a group health plan, continue health care coverage for yourself, spouse, or dependents if there's a loss of coverage under the group health plan as a result of a qualifying event. You or your dependents may have to pay for such coverage.
- Review this SPD and the documents governing the Plan regarding the rules governing your *COBRA* continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate your Plan, called fiduciaries, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries.

No one, including your employer or any other person, may discharge you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

Enforce Your Rights

If your *claim* for a benefit is denied or ignored in whole or in part, you must receive a written explanation of the reasons for the denial. You have the right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. No lawsuit shall be brought against the Plan, the *Company*, or the Plan Administrator after 90 days from receipt of the final decision on a *claim* appeal.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials about the Plan and don't receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials—unless the materials weren't sent because of reasons beyond the control of the Plan Administrator.

If you have a *claim* for benefits that's denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in a federal court.

If it should happen that Plan fiduciaries misuse the Plan's money, or if you're discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you're successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees—for example, if it finds your *claim* is frivolous.

Assistance With Your Questions

If you have any questions about the Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, DC 20210.

You also may obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration, or by logging on to the Internet at **www.dol.gov/ebsa**. You can also contact the Employee Benefits Security Administration field office nearest you.

Glossary

Accident

A sudden, unexpected, and unforeseen identifiable occurrence or event that produces (at the time) objective symptoms of a bodily injury. The accident must occur while the person is covered under this Plan. The occurrence or event must be definite as to time and place. It must not be due to or contributed by an illness or disease of any kind. Blue Cross Blue Shield requires that treatment must be sought as soon as reasonably possible.

Active Work (Actively at Work)

You're considered to be actively at work on:

- A day that you actively perform all customary duties as an employee at either your Company's place of business or at some other location to which you're required to travel for business.
- A day that's not one of your regularly scheduled workdays or a day that's eligible for pay under the Company's paid-time-off policies, provided you were actively at work on the last preceding scheduled workday.

If you're absent from work due to your illness or your hospital confinement, you'll be treated as being actively at work for purposes of the Plan.

Advanced Practice Nurse

A certified clinical nurse specialist, certified nurse-midwife, certified nurse practitioner, or certified registered nurse anesthetist.

Ambulance Services/Transportation

Local transportation service in a specially equipped, licensed, certified vehicle from your home, scene of an accident, or medical emergency:

- Between one hospital and another hospital;
- Between one hospital and a skilled nursing care facility;
- To a hospital; or
- From one skilled nursing care facility or hospital to your home.

If no facilities in your local area are equipped to provide the care you need, ambulance services then means transportation to the closest facility that can provide such necessary care.

Ambulatory Surgical Facility

A facility (other than a hospital) whose primary function is the provision of surgical procedures on an ambulatory basis and which is duly licensed by the appropriate state and local authority to provide such services. An “administrator ambulatory surgical facility” means an ambulatory surgical facility which has a written agreement with the claims administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered to you. A “non-administrator ambulatory surgical facility” means an ambulatory surgical facility which does not meet the definition of an administrator ambulatory surgical facility.

Anesthesia Services

The administration of anesthesia and the performance of related procedures by a physician or a certified registered nurse anesthetist which may be legally rendered by them respectively.

Appeals Addressing Benefit Issues

A claim for a particular benefit under the Plan. It typically includes your initial request for benefits. If you're filing a benefit claim, you need to contact the claims administrator.

Behavioral Health Disorder (Mental Disorder)

A disease that's commonly understood to be a mental disorder whether or not it has a physiological or organic basis and for which treatment is generally provided by or under the direction of a mental health professional (e.g., a psychiatrist, *psychologist*, or psychiatric social worker). Such disorders include:

- Alcoholism and drug abuse;
- Schizophrenia;
- Bipolar disorders;
- Pervasive Mental Developmental Disorder;
- Panic disorders;
- Major depressive disorders;
- Psychotic depression;
- Obsessive compulsive disorders;
- Paranoid and other psychotic disorders;
- Schizoaffective disorders (bipolar & depressive);
- Depression in childhood and adolescence;
- Post-traumatic stress disorder (acute, chronic or with delayed onset); or
- Anorexia nervosa and bulimia nervosa.

Behavioral Health Provider

A licensed organization or professional that is duly licensed to render services e.g. diagnostic, therapeutic, or psychological for mental illness, serious mental Illness, or substance abuse disorders.

Certificate of Creditable Coverage

If your coverage under the Plan ends, you can request a certificate of group health plan coverage. You may take this certificate to another health care plan and receive credit for your coverage under this Plan towards any pre-existing condition exclusions or limitations your next health care plan may have (this Plan, for example, doesn't have a pre-existing condition limitation). You can request a certificate of group health plan coverage anytime during the 24-month period after your coverage under this Plan ends (and at any other times as required by law).

Certified Clinical Nurse Specialist

A nurse specialist who (a) is licensed under the Nursing and Advanced Practice Nursing Act; (b) has an arrangement or agreement with a physician for obtaining medical consultation; collaboration and hospital referral; and (c) meets the following qualifications:

- Is a graduate of an approved school of nursing and holds a current license as a registered nurse; and
- Is a graduate of an advanced practice nursing program.

A “participating certified clinical nurse specialist” means a certified clinical nurse specialist who has a written agreement with the claims administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A “non-participating certified clinical nurse specialist” means a certified clinical nurse specialist who does not have a written agreement with the claims administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

Certified Nurse-Midwife

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

- Is a graduate of an approved school of nursing and holds a current license as a registered nurse; and
- Is a graduate of a program of nurse-midwives accredited by the American College of Nurse Midwives or its predecessor.

A “participating certified nurse-midwife” means a certified nurse-midwife who has a written agreement with the claims administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A “non-participating certified nurse-midwife” means a certified nurse-midwife who does not have a written agreement with the claims administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

Certified Nurse Practitioner

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

- Is a graduate of an approved school of nursing and holds a current license as a registered nurse; and
- Is a graduate of an advanced practice nursing program.

A “participating certified nurse practitioner” means a certified nurse practitioner who has a written agreement with the claims administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A “non-participating certified nurse practitioner” means a certified nurse practitioner who does not have a written agreement with the claims administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

Certified Registered Nurse Anesthetist or CRNA

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

A “participating certified registered nurse anesthetist” means a certified registered nurse anesthetist who has a written agreement with the claims administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A “non-participating certified registered nurse anesthetist” means a certified registered nurse anesthetist who does not have a written agreement with the claims administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

Chemotherapy

The treatment of malignant conditions by pharmaceutical and/or biological anti-neoplastic drugs.

Chiropractor

A licensed chiropractor.

Claim

Notification in a form acceptable to the claims administrator that a service has been rendered or furnished to you. This notification must include full details of the service received, including your name, age, sex, identification number, the name and address of the provider, an itemized statement of the service rendered or furnished, the date of service, the diagnosis, the claim charge, and any other information which the claims administrator may request in connection with services rendered to you.

Claims Administrator

Blue Cross and Blue Shield of Illinois.

Claim Charge

The amount which appears on a claim as the provider's charge for service rendered to you, without adjustment or reduction and regardless of any separate financial arrangement between the claims administrator and a particular provider.

Claim Payment

The benefit payment calculated by the claims administrator, after submission of a claim, in accordance with the benefits described in this SPD. All claim payments will be calculated on the basis of the eligible charge for covered services rendered to you, regardless of any separate financial arrangement between the claims administrator and a particular Provider.

If you pay the bill at the time of service and submit a claim for reimbursement, the check you receive from the Claims Administrator must be cashed in a timely manner. The Company does not reimburse claim payments.

Clinical Laboratory

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

A "participating clinical laboratory" means a clinical laboratory which has a written agreement with the claims administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A "non-participating clinical laboratory" means a clinical laboratory which does not have a written agreement with the claims administrator or another Blue Cross and/or Blue Shield Plan provides services to you at the time services are rendered.

COBRA

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

Code

The Internal Revenue Code and its applicable regulations.

Coinsurance

A percentage of an eligible expense that you are required to pay towards a covered service.

Companion

With regard to solid organ and bone marrow transplants, a companion is an individual whose presence as a companion or caregiver is necessary to enable you to:

- Receive services related to a procedure or treatment on an inpatient or outpatient basis; or
- Travel to and from the facility where the treatment is provided.

Company (Employer)

Wolters Kluwer United States Inc. and its subsidiaries that have adopted the Plan. Please also see the "Administrative Information" main section for a list of subsidiaries that participate in and have adopted the Plan.

Coordinated Home Care Program

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

An "administrator coordinated home care program" means a coordinated home care program which has a written agreement with the claims administrator or another Blue Cross and/or Blue Shield Plan to provide service to you at the time service is rendered to you.

A "non-administrator coordinated home care program" means a coordinated home care program which does not have an agreement with the claims administrator or a Blue Cross Plan but has been certified as a home health agency in accordance with the guidelines established by Medicare.

Copay

A specified dollar amount that you are required to pay towards a covered service.

Cosmetic

Services that are provider primarily to alter and or enhance appearance in the absence of documented physical impairment of physical function.

Course of Treatment

Any number of dental procedures or treatments performed by a dentist or physician in a planned series resulting from a dental examination in which the need for such procedures or treatments was determined.

Covered Service

A service and supply specified in this SPD for which benefits will be provided.

Custodial Care Service

Any service primarily for personal comfort or convenience that provides general maintenance, preventive, and/or protective care without any clinical likelihood of improvement of your condition.

Custodial care services also means those services which do not require the technical skills, professional training, and clinical assessment ability of medical and/or nursing personnel in order to be safely and effectively performed. These services can be safely provided by trained or capable non-professional personnel, are to assist with routine medical needs (e.g., simple care and dressings, administration of routine medications, etc.) and are to assist with activities of daily living (e.g., bathing, eating, dressing, etc.). Custodial care service also means providing care on a continuous Inpatient or outpatient basis without any clinical improvement by you.

Deductible

The fixed dollar amount that must be paid for eligible services or supplies before claims for health services or supplies received from providers are reimbursable as benefits under the Plan.

Dentist

A legally qualified dentist, including a physician who's licensed to do the dental work that he or she performs.

Diagnostic Service

Tests rendered for the diagnosis of your symptoms and which are directed toward evaluation or progress of a condition, disease, or injury. Such tests include, but are not limited to, X-rays, pathology services, clinical laboratory tests, pulmonary function studies, electrocardiograms, electroencephalograms, radioisotope tests, and electromyograms.

Dialysis Facility

A facility (other than a hospital) whose primary function is the treatment and/or provision of maintenance and/or training dialysis on an ambulatory basis for renal dialysis patients and which is duly licensed by the appropriate governmental authority to provide such services.

An “administrator dialysis facility” means a dialysis facility which has a written agreement with the claims administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered to you.

A “non-administrator dialysis facility” means a dialysis facility which does not have an agreement with the claims administrator or another Blue Cross and/or Blue Shield Plan but has been certified in accordance with the guidelines established by Medicare.

Directory

A listing of network providers the Plan considers to be in the service area. This Directory is available online and can be provided to all Plan participants upon request and is free of charge.

Domestic Partner

Your domestic partner is an individual of the same or opposite sex who:

- Shares your permanent residence.
- Has resided with you for no less than one year.
- Is not younger than 18 years of age.
- Is financially interdependent with you and has proven such interdependence by providing documentation of at least two (three for certain coverages) of the following arrangements:
    - Common ownership of real estate property or a common leasehold interest in such property;
    - Common ownership of a motor vehicle;
    - A joint bank or credit account;
    - Designation as a beneficiary for life insurance or retirement benefits under your partner's will;
    - Assignment of durable power of attorney or health care power of attorney; or
    - Any such other proof that the claims administrator considers sufficient to establish financial interdependency under the circumstances of your particular case.
- Isn't a blood relative any closer than would prohibit legal marriage.
- Has signed, jointly with you, a notarized affidavit that can be made available to the claims administrator upon request.

The Plan considers both you and your domestic partner to meet the terms of the above definition as long as neither you nor your domestic partner:

- Is currently legally married to another person; or
- Has any other domestic partner, spouse, or spouse equivalent of the same or opposite sex.

You and your domestic partner must register as domestic partners if you reside in a state or locality that provides for such registration.

Durable Medical and Surgical Equipment

DME is eligible for coverage when the equipment meets all of the following criteria:

- Serves a medical purpose;
- Generally not useful to a person in the absence of illness, injury, or disease;
- Appropriate for use in the home;
- Reasonable and medically necessary for the individual patient;
- Prescribed by a physician within the scope of his or her license;
- Does not serve as a comfort or convenience item; and
- Has been approved by the U.S. Food and Drug Administration (FDA) (where applicable) and is otherwise generally considered to be safe and effective for the purpose intended.

The following list includes, but is not limited to, examples of items that are not eligible for coverage:

- Room or central environmental conditioning devices, including but not limited to air cleaners, air conditioners, humidifiers, dehumidifiers, electrostatic machines, heaters;
- Bathing devices, including but not limited to whirlpool tubs and/or pumps, sauna bath;
- Exercise equipment, treadmill exerciser, elevators;
- Leotards and other clothing type items;
- Supplies that are usually stocked in the home for general use, including but not limited to Band-Aids, thermometers, lubricating jelly, etc.; and
- Transportation equipment, including but not limited to customized vehicles (cars, vans, etc.), car seats, etc.

Elective Surgery

A surgical procedure that's not considered emergency in nature and may be avoided (for at least 24 hours) without undue risk to your health.

Eligibility Issues

A claim to participate in a coverage option or to change a coverage election to participate during the Plan Year (e.g., a request to switch from one available coverage option to another mid-year). If you're filing an eligibility claim, you must contact Your Benefits Resources.

Eligible Charge

In the case of a provider, other than a professional provider, which has a written agreement with the claims administrator or another Blue Cross and/or Blue Shield Plan to provide care to you at the time covered services are rendered, such provider's claim charge for covered services. in the case of a provider, other than a professional provider, which does not have a written agreement with the claims administrator or another Blue Cross and/or Blue Shield Plan to provide care to you at the time covered services are rendered, will be the lesser of:

- The provider's billed charges; or
- The claims administrator non-contracting eligible charge.

Except as otherwise provided in this SPD, the non-contracting eligible charge is developed from base Medicare reimbursements and represents approximately 100% of the base Medicare reimbursement rate and will exclude any Medicare adjustment(s) which is/are based on information on the Claim. Notwithstanding the preceding sentence, the non-contracting eligible charge for coordinated home care program covered services will be 50% of the non-participating or non-administrator provider's standard billed charge for such covered services.

The base Medicare reimbursement rate described above will exclude any Medicare adjustment(s) which is/are based on information on the claim. When a Medicare reimbursement rate is not available for a covered service or is unable to be determined on the information submitted on the claim, the eligible charge for non-participating or non-administrator providers will be 50% of the non-participating or non-administrator provider's standard billed charge for such covered service. The claims administrator will utilize the same claim processing rules and/or edits that it utilizes in processing participating provider claims for processing claims submitted by non-participating or non-administrator providers which may also alter the eligible charge for a particular service. In the event the claims administrator does not have any claim edits or rules, the claims administrator may utilize the Medicare claim rules or edits that are used by Medicare in processing the claims. The eligible charge will not include any additional payments that may be permitted under the Medicare laws or regulations which are not directly attributable to a specific claim, including, but not limited to, disproportionate share payments and graduate medical education payments. Any change to the Medicare reimbursement amount will be implemented by the claims administrator within 145 days after the effective date that such change is implemented by the Centers for Medicaid and Medicare Services, or its successor.

Eligible Person

An employee of the Company who meets the eligibility requirements for this health and/or dental coverage, as described in the "Eligibility" main section.

Emergency Accident Care

Initial outpatient treatment of accidental injuries including related diagnostic services.

Emergency Medical Care

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

- Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

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

Emergency Medical Condition

A recent onset and severity (including but not limited to severe pain) that would lead a prudent layperson who possesses an average knowledge of medicine and health to believe that his or her condition, illness, or injury is of such a nature that failure to receive immediate medical care could result in:

- Placing your health in serious jeopardy;
- Serious impairment to bodily function;
- Serious dysfunction of a body part or organ; or
- Serious jeopardy to the health of the fetus (in the case of a pregnant woman).

Emergency Mental Illness or Substance Abuse Admission

An admission for the treatment of mental illness or substance abuse disorders as a result of the sudden and unexpected onset of a mental illness or substance abuse condition such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect that in the absence of immediate medical treatment would likely result in serious and permanent medical consequences to oneself or others.

Formulary

A prescription drug with a proprietary brand-name drug that's chosen for its ability to meet patient needs at a lower cost. The claims administrator's drug formulary is a list of preferred drugs selected by a panel of physicians and pharmacists that are proven to be effective and cost-efficient in treating specific illnesses or conditions. The formulary includes all generic drugs and a select group of brand-name drugs. All drugs are evaluated on their comparative safety, efficacy, uniqueness, and cost-effectiveness.

If a generic drug isn't available, there may be more than one formulary brand-name drug available to treat a condition. You pay more when you purchase brand-name drugs that aren't on the prescription drug formulary list.

Free-Standing Birthing Center

To qualify as a free-standing birthing center, a facility must:

- Meet licensing standards;
- Be set up, equipped, and run to provide prenatal care, delivery, and immediate postpartum care;
- Make charges;
- Operate under the direction of at least one physician who is a specialist in obstetrics and gynecology;
- Have a physician or certified nurse-midwife present at all births and during the immediate post-partum period;
- Extend staff privileges to physicians who practice obstetrics and gynecology in an area hospital;
- Have at least two beds or two birthing rooms for use by patients while in labor and during delivery;
- Provide for during labor, delivery, and the immediate postpartum period, full-time skilled nursing services directed by an R.N. or certified nurse-midwife;
- Provide for, or arrange with a facility in the area, diagnostic X-ray and lab services for the mother and child;
- Have the capacity to administer a local anesthetic and to perform minor surgery (including episiotomies and the repair of perineal tears);
- Be equipped, have trained staff that's able to handle medical emergencies, and be able to provide immediate support measures to sustain life if complications arise during labor and during delivery if a child is born with an abnormality that impairs function or threatens life;
- Accept only patients with low-risk pregnancies;
- Have a written agreement with a hospital in the area for emergency transfer of a patient or child (written procedures for such a transfer must also be displayed, and the staff must be aware of such procedures);
- Provide an ongoing quality assurance program, including reviews by physicians who don't own or direct the facility; and
- Keep a medical record on each patient and child.

Free-Standing Surgical Facility

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

Full-time Employee

You're a Full-time Employee if you're:

- Hired on a permanent full-time basis; and
- Regularly scheduled to work at least 30 hours per week.

Full-time Employees include common law employees, as defined by applicable law.

The following aren't Full-time Employees:

- An individual who's regularly scheduled to work less than 30 hours per week required by the Company for full-time employment;
- An individual who hasn't met the applicable waiting period for coverage under the applicable Plan, if any;
- An individual whose terms of employment are subject to a collective bargaining agreement;
- On-call employees;
- An individual whose compensation isn't treated by the Company at the time of payment as being subject to payroll tax withholding (i.e., contract employees);
- Independent contractors or leased employees; or
- Nonresident aliens who don't receive any United States source earned income.

The Plan Administrator has the exclusive right to classify an individual as a Full-time Employee. Classification, reclassification, or retroactive classification of an individual's status with the Company by any other entity (even a court or government agency) won't cause the individual to become a Full-time Employee for purposes of this Plan.

Generic Drugs

Generic drugs are less expensive for you and for the Company. As a result, they're more affordable and help keep the Plan more affordable. This is why your prescription is automatically filled with a generic (or formulary brand-name drug), unless your provider specifically indicates that a non-formulary brand-name drug be used. This also is referred to as “dispense as written.”

Generic drugs are approved by the FDA as therapeutically equivalent and interchangeable with drugs having an identical amount of the same active ingredient. So, they have the same effectiveness, quality, safety, and strength as brand-name drugs. Most health care professionals believe that generic drugs are as effective and safe as non-formulary drugs. In addition, they cost you and the Company a fraction of the cost of non-formulary brand-name medications. Nevertheless, the decision regarding whether to use a generic, formulary, or non-formulary brand-name drug is ultimately up to you and your provider.

Home Infusion Therapy Provider

Duly licensed home infusion therapy provider.

A “participating home infusion therapy provider” means a home infusion therapy provider who has a written agreement with the claims administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A “non-participating home infusion therapy provider” means a home infusion therapy provider who does not have a written agreement with the claims administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

Hospice Care

A centrally administered program designed to provide for the physical, psychological, and spiritual care for dying persons and their families. The goal of hospice care is to allow the dying process to proceed with a minimum of patient discomfort while maintaining dignity and a quality of life. Hospice care program service is available in the home, skilled nursing facility or special hospice care unit.

Hospice Care Agency

An organization duly licensed to provide hospice care program service.

Hospice Care Program Provider

Duly licensed to provide hospice care program service

Hospice Care Program Service

A centrally administered program designed to provide for the physical, psychological and spiritual care for dying persons and their families. The goal of hospice care is to allow the dying process to proceed with a minimum of patient discomfort while maintaining dignity and a quality of life. Hospice care program service is available in the home, skilled nursing facility, or special hospice care unit.

Hospice Facility

An organization duly licensed to provide Hospice Care Program Service.

Hospital

A duly licensed institution for the care of the sick which provides service under the care of a physician including the regular provision of bedside nursing by registered nurses. It does not mean health resorts, rest homes, nursing homes, skilled nursing facilities, convalescent homes, custodial homes of the aged, or similar institutions.

An “administrator hospital” means a hospital which has a written agreement with the claims administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered to you.

A “non-administrator hospital” means a hospital that does not meet the definition of an administrator hospital.

A “participating hospital” means an administrator hospital that has an agreement with the claims administrator or another Blue Cross and/or Blue Shield Plan to provide hospital services to participants in the PPO coverage option.

A “non-participating hospital” means an administrator hospital that does not meet the definition of a participating hospital.

Hospital Confinement (Confinement)

Period of time lasting from the first day a Blue Cross Blue Shield member receives covered inpatient hospital services until the member is discharged (or until the number of hospital days in the member's benefit contract are exhausted). Any period of over 23 hours is considered inpatient.

Illness

This is a non-occupational illness that doesn't:

- Arise out of (or in the course of) any work for pay or profit; or
- Result in any way from an illness that does.

An illness is deemed to be non-occupational regardless of cause if you furnish proof that you're:

- Not covered under any type of Workers' Compensation Law; or
- Not covered for that particular illness under such law.

An illness can be any physical or mental illness, including pregnancy.

Individual Benefits Management Program

Under certain circumstances, the Plan modifies its benefits to pay for alternative services and supplies to treat a catastrophic illness or injury (e.g., a head injury that requires an inpatient stay, spinal cord injury, severe burns, multiple injuries due to an accident, etc.). The Plan must approve your alternative treatment in advance. Such alternative treatment includes services and supplies that are:

- Determined by the Plan to be medically necessary and cost-effective to meet the long-term or intensive care needs of a catastrophically ill or injured individual; and
- Not otherwise payable under the Plan.

Alternative treatment doesn't include any service or supply that the Plan determines is experimental or investigational.

Infertile or Infertility

The condition of a presumably healthy covered person who's unable to conceive or produce conception after one year of unprotected sexual intercourse or the inability to sustain a successful pregnancy. The one-year requirement will be waived if your physician determines a medical condition exists that makes conception impossible through unprotected sexual intercourse including, but not limited to, congenital absence of the uterus or ovaries, absence of the uterus or ovaries due to surgical removal due to a medical condition, or involuntary sterilization due to chemotherapy or radiation treatments; or, efforts to conceive as a result of one year of medically based and supervised methods of conception, including artificial insemination, have failed and are not likely to lead to a successful pregnancy. Unprotected sexual intercourse means sexual union between a male and female without the use of any process, device, or method that prevents conception including, but not limited to, oral contraceptives, chemicals, physical or barrier contraceptives, natural abstinence, or voluntary permanent surgical procedures, and includes appropriate measures to ensure the health and safety of sexual partners.

Injectable Medications (Drugs)

The most common injectable medications include:

- Matrix;
- Lovanox;
- Fragmin;
- Glucagon;
- Insulin; and
- Bee-sting kits.

Please see the claims administrator's website to confirm that your injectable medication is covered under the Plan. The site also contains additional information regarding covered prescription drug services.

Injury

A non-occupational accidental bodily injury that doesn't:

- Arise out of (or in the course of) any work for pay or profit; or
- Result in any way from an injury that does.

Inpatient

You are a registered bed patient and are treated as such in a health care facility.

Investigational, or Investigational Services and Supplies

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

Long-Term or Maintenance Medications

A drug that you take on a regular basis to treat an ongoing chronic health condition. The following conditions are examples of those that require long-term medications:

- High blood pressure;
- Ulcers;
- Arthritis;
- Allergies and asthma;
- Heart or thyroid conditions; and
- Diabetes.

Maintenance Care

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

Maintenance Occupational Therapy, Maintenance Physical Therapy, and/or Maintenance Speech Therapy

Therapy administered to you to maintain a level of function at which no demonstrable and measurable improvement of a condition will occur.

Maternity Service

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

Maximum Allowance

The amount that participating professional providers have agreed to accept as payment in full for a particular covered service. All benefit payments for covered services rendered by participating professional providers will be based on the schedule of maximum allowances that these providers have agreed to accept as payment in full.

For non-participating professional providers, the maximum allowance will be the lesser of:

- The provider's billed charges, or;
- The claims administrator's non-contracting maximum allowance.

Except as otherwise provided in this section, the non-contracting maximum allowance is developed from base Medicare reimbursements and represents approximately 100% of the base Medicare reimbursement rate and will exclude any Medicare adjustment(s) which is/are based on information on the claim. Notwithstanding the preceding sentence, the non-contracting maximum allowance for coordinated home care program covered services will be 50% of the non-participating professional provider's standard billed charge for such covered services.

The base Medicare reimbursement rate described above will exclude any Medicare adjustment(s) which is/are based on information on the claim.

When a Medicare reimbursement rate is not available for a covered service or is unable to be determined on the information submitted on the claim, the maximum allowance for non-participating professional providers will be 50% of the non-participating professional provider's standard billed charge for such covered service. The claims administrator will utilize the same claim processing rules and/or edits that it utilizes in processing participating professional provider claims for processing claims submitted by non-participating professional providers which may also alter the maximum allowance for a particular service. In the event the claims administrator does not have any claim edits or rules, the claims administrator may utilize the Medicare claim rules or edits that are used by Medicare in processing the claims. The maximum allowance will not include any additional payments that may be permitted under the Medicare laws or regulations which are not directly attributable to a specific claim, including, but not limited to, disproportionate share payments and graduate medical education payments. Any change to the Medicare reimbursement amount will be implemented by the claims administrator within 145 days after the effective date that such change is implemented by the Centers for Medicaid and Medicare Services, or its successor.

Medicaid

A state program of medical aid for needy persons. This program was established under Title XIX of the Social Security Act of 1965 as amended.

Medical Care

The ordinary and usual professional services rendered by a physician or other specified provider during a professional visit for treatment of an illness or injury.

Medicare

The program of medical care benefits provided under Title XVIII of the Social Security Act (42 U.S.C. _1395 et seq.).of 1965 as amended. This is a government-sponsored health insurance program for people age 65 and older or those who are disabled. The government, from time to time, has considered increasing the Medicare age. The Social Security Administration manages and finances this coverage. Medicare has two parts:

- Coverage under Part A, which provides hospital benefits; and
- Coverage under Part B, which provides additional benefits.

Part A coverage is provided at no cost to you. However, you're required to pay the cost of Part B coverage (an optional coverage).

Medicare Approved or Medicare Participating

A provider which has been certified or approved by the Department of Health and Human Services for participating in the Medicare program.

Medicare Secondary Payer (MSP)

Those provisions of the Social Security Act set forth in 42 U.S.C._1395 y (b), and the implemented regulations set forth in 42 C.F.R. Part 411, as amended, which regulate the manner in which certain employers may offer group health care coverage to Medicare-eligible employees, their spouses and, in some cases, dependent children.

Mental Health Unit

A unit established to assist in the administration of mental illness and substance abuse rehabilitation treatment benefits including preauthorization, emergency mental illness or substance abuse admission review, and length of stay/service review for inpatient hospital admissions for the treatment of mental illness and substance abuse disorders.

Mental Illness

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

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

- Schizophrenia;
- Paranoid and other psychotic disorders;
- Bipolar disorders (hypomanic, manic, depressive and mixed);
- Major depressive disorders (single episode or recurrent);
- Schizoaffective disorders (bipolar or depressive);
- Pervasive developmental disorders;
- Obsessive-compulsive disorders;
- Depression in childhood and adolescence;
- Panic disorder;
- Post-traumatic stress disorders (acute, chronic, or with delayed onset); and
- Anorexia nervosa and bulimia nervosa.

Mentally or Physically Disabled

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

Negotiated Fee

For purposes of Plan benefits, this is the maximum amount (maximum allowance) that a network provider agrees to charge for covered services.

Network Care

Care provided by network (participating) providers as defined below.

Network (Participating) Providers

An administrator hospital or professional provider which has a written agreement with the claims administrator or another Blue Cross and/or Blue Shield Plan to provide services for a negotiated fee to participants in the Blue Cross Blue Shield National coverage options or an administrator facility which has been designated by the claims administrator as a participating provider.

Providers that qualify as network providers may change from time to time. A list of the current participating providers is available online.

Non-Formulary

These are drugs that aren't included on the formulary list. Most health plans charge more for non-formulary brand-name drugs.

Non-Network Provider

An administrator hospital or professional provider which does not have a written agreement with the claims administrator or another Blue Cross and/or Blue Shield Plan to provide services to participants in the PPO coverage option or a facility which has not been designated by the claims administrator as a Participating Provider.

A provider’s status may change from time to time. A list of the current participating providers is available on the Your Benefits Resources website.

Non-Participating Pharmacy

A pharmacy that doesn't sign an agreement with the claims administrator and doesn't accept the negotiated fee as payment in full. As a result, you're responsible for paying the full cost of these services. If you fill your prescription at a non-participating pharmacy, the Plan doesn't pay benefits.

Normal Pregnancy

An intrauterine pregnancy that, through vaginal delivery, results in an infant.

Nurse

A nurse includes a:

- Registered Graduate Nurse (R.N.);
- Licensed Practical Nurse (L.P.N.); or
- Licensed Vocational Nurse who has the right to use the abbreviation “R.N.,” “L.P.N.” or “L.V.N.”

Occupational Therapy

Constructive therapeutic activity that's designed and adapted to promote the restoration of useful physical function. Occupational therapy doesn't include educational training or services designed and adapted to develop a physical function.

Out-of-Network Care (Services)

Services provided to patients who live outside the network or who choose not to use network providers. The Plan pays benefits for such eligible expenses at a lower level of benefit. In addition, these services are subject to maximum allowance.

If you use an out-of-network provider, you can incur additional out-of-pocket expenses.

Out-of-Network Provider

A health care professional, institution, facility, or agency that doesn't sign an agreement with the claims administrator to accept the negotiated fee as payment in full. If you receive care from an out-of-network or non-network provider, the Plan pays a lower level of benefit.

Outpatient

You are receiving treatment while not an inpatient. Services considered outpatient, include, but are not limited to, services in an emergency room regardless of whether you are subsequently registered as an inpatient in a health care facility.

Partial Hospitalization Treatment Program

Claims administrator-approved planned program of a hospital or substance abuse treatment facility for the treatment of mental illness or substance abuse rehabilitation treatment in which patients spend days or nights.

Participating Provider Option

A program of health care benefits designed to provide you with economic incentives for using designated providers of health care services.

Part-time Employee

You're a Part-time Employee if you're:

- Hired on a permanent basis; and
- Regularly scheduled to work at least 20 hours per week.

Part-time Employees include common law employees, as defined by applicable law.

The following aren't Part-time Employees:

- An individual who's regularly scheduled to work less than 20 hours per week;
- An individual who hasn't met the applicable waiting period for coverage under the applicable Plan, if any;
- An individual whose terms of employment are subject to a collective bargaining agreement;
- On-call employees;
- An individual whose compensation isn't treated by the Company at the time of payment as being subject to payroll tax withholding (i.e., contract employees);
- Independent contractors or leased employees; or
- Nonresident aliens who don't receive any United States source earned income.

The Plan Administrator has the exclusive right to classify an individual as a Part-time Employee. Classification, reclassification, or retroactive classification of an individual's status with the Company by any other entity (even a court or government agency) won't cause the individual to become a Part-time Employee for purposes of this Plan.

Participating Pharmacies

A pharmacy that has a written agreement with the claims administrator to dispense drugs to covered participants. These pharmacies participate in a network, which includes national and regional chain stores. The network also includes many independent pharmacies. To determine whether or not your pharmacy participates in the network, go to the online Directory, or call the claims administrator.

Physical Therapist

Duly licensed physical therapist.

Physical Therapy

The treatment of an illness, injury, or condition by physical and mechanical means. A physician—or a registered professional physical therapist under the supervision of a physician—must provide such therapy. This type of therapy is designed to promote the restoration of a useful physical function. Physical therapy doesn't include educational training or services designed and adapted to develop a physical function.

Physician

A physician duly licensed to practice medicine in all of its branches.

Physician Assistant

A duly licensed physician assistant performing under the direct supervision of a physician, dentist, or podiatrist and billing under such provider.

Plan Year

The Plan Year is January 1 through December 31.

Podiatrist

A duly licensed podiatrist.

Preauthorization, Preauthorize, or Emergency Mental Illness or Substance Abuse Admission Review

A submission of a request to the mental health unit for a determination of medically necessary care.

Preventive Care

Specific screenings and early-intervention medical care that's designed to detect medical problems. Such procedures also encourage good health.

Primary Care Physician (PCP)

A preferred care provider who is:

- Selected by you—required if you're enrolled in an HMO, suggested if you're enrolled in one of the Blue Cross Blue Shield National coverage options—from the list of PCPs in the Directory;
- Responsible for your or your covered dependent's ongoing care; and
- Shown on the HMO's records as your PCP (for the HMO options).

A PCP may be a family practitioner, internist, pediatrician, or general practitioner who works within a particular provider network. He or she not only provides treatment, but also coordinates care, studies medical histories, monitors health, and reviews records from any other physician you or your covered family member may visit.

A Blue Cross Blue Shield PCP is further defined as one of the following:

- General Practice;
- Family Practice;
- Gynecology (Osteopath Only);
- Internal Medicine;
- OB/GYN;
- Pediatrics;
- Certified Nurse Midwives;
- Mixed Specialty Group;
- Registered Nurse;
- Licensed Practical Nurse;
- Certified Registered Nurse;
- Anesthetist;
- Optometrist;

- Optician;
- Certified Nurse Specialist;
- Certified Nurse Practitioner (CNP);
- Retail Health; and,
- Behavioral Health Specialists: Psychiatry), Licensed Clinical Professional Counselors (LCPC), Clinical Psychology, Psychiatric or Medical Social Worker, Mixed Group (LCSW, LCPC & LMFT) (101)m Neuropsychologist.

Private Duty Nursing Service

If skilled nursing service provided on a one-to-one basis by an actively practicing registered nurse (R.N.), or licensed practical nurse (L.P.N.). Private duty nursing is shift nursing of eight hours or greater per day and does not include nursing care of less than eight hours per day. Private duty nursing service does not include custodial care service.

Prosthetic Appliances

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

Prosthetic Provider

A duly licensed prosthetic provider.

A “participating prosthetic provider” means a prosthetic provider who has a written agreement with the claims administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A “non-participating prosthetic provider” means a prosthetic provider who does not have a written agreement with the claims administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

Provider

Any health care facility (for example, a hospital or skilled nursing facility) or person (for example, a physician or dentist) or entity duly licensed to render covered services to you.

A “professional provider” means a physician, dentist, podiatrist, psychologist, chiropractor, optometrist, or any provider designated by the claims administrator or another Blue Cross and/or Blue Shield Plan. A “participating prescription drug provider” means a pharmacy that has a written agreement with the claims administrator or the entity chosen by the claims administrator to administer its prescription drug program to provide services to you at the time you receive the services.

Psychiatric Physician

A physician who:

- Specializes in psychiatry; or
- Has the training or experience to do the required evaluation and treatment of mental illness.

Psychologist

A registered clinical psychologist. “Registered clinical psychologist” means a clinical psychologist who is licensed by the state in which he or she practices pursuant to the Illinois “Psychologists Registration Act” or, in a state where statutory licensure exists, the clinical psychologist must hold a valid credential for such practice or, if practicing in a state where statutory licensure does not exist, such person must meet the qualifications specified in the definition of a clinical psychologist.

“Clinical psychologist” means a psychologist who specializes in the evaluation and treatment of mental illness and who meets the following qualifications:

- Has a doctoral degree from a regionally accredited university, college or professional school; and has two years of supervised experience in health services of which at least one year is post-doctoral and one year is in an organized health services program; or
- Is a registered clinical psychologist with a graduate degree from a regionally accredited university or college; and has not less than six years as a psychologist with at least two years of supervised experience in health services.

Qualified Medical Child Support Order (QMCSO)

A Qualified Medical Child Support Order (QMCSO) is a state court order that requires a parent to provide medical support to a child, often because of legal separation or divorce. A QMCSO may be either a National Medical Child Support Notice that's issued by a state child support agency, or an order or a judgment from a state court or administrative body that directs this Plan to cover your child (even though, for income tax or plan purposes, the child may not be your dependent).

A QMCSO can't require the Plan to cover any type or form of benefit not otherwise offered. However, an order may require the Plan to comply with state laws regarding a child's coverage.

Federal law provides that a QMCSO must meet certain form and content requirements to be valid. The Company follows certain procedures to determine if a child support notice is “qualified.” You and the affected child will be notified if an order is received and will receive a copy of the QMCSO.

Renal Dialysis Treatment

One unit of service including the equipment, supplies, and administrative service which are customarily considered as necessary to perform the dialysis process.

Respite Care Service

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

Room and Board

Charges made by an institution for room and board and other necessary services and supplies, including room, meals, and all general services and activities necessary to care for you as a registered bed patient.

The services must be regularly provided at a daily or weekly rate.

Self-Funded

If you're a participant in one of the Blue Cross Blue Shield National coverage options, your coverage under the Plan is self-funded. This means that the Plan pays claims from the Company's assets and the Company has an administrative services contract with the claims administrator to process claims.

Self-Injectable Drug(s)

Prescription drugs that are intended to be self-administered by injection to a specific part of the body to treat medical conditions.

Serious Health Condition

An illness, injury, impairment, or physical or mental condition that involves either:

- Any period of incapacity or treatment that's connected with inpatient care in a hospital, hospice, or residential medical care facility, and any period of incapacity or subsequent treatment in connection with such inpatient care; or
- Continuing treatment by a health care provider which includes any period of incapacity due to any of the following:
    - A health condition (including prior treatment and recovery) lasting more than three consecutive days; and any subsequent treatment or period of incapacity relating to the same condition, that also includes:
        - Treatment two or more times by or under the supervision of a health care provider (both visits must occur within 30 days of the start of the incapacity, and the first visit must occur within seven days of the first day of incapacity); or
        - One treatment by a health care provider with a continuing regiment of treatment (the first and only visit must occur within seven days of the first day of incapacity).
    - Pregnancy or prenatal care. A visit to the health care provider isn't necessary for each absence.
    - A chronic, serious health condition that continues over any extended period of time, requires periodic visits to a health care provider (at least two visits per year), and may involve occasional episodes of incapacity. A visit to a health care provider isn't necessary for each absence.

- A permanent or long-term condition for which treatment may not be effective (only supervision by a health care provider is required, rather than active treatment).
- Any absences to receive multiple treatments for restorative surgery or for a condition that would likely result in a period of incapacity of more than three days if not treated.

Short-Term Medications

A short-term medication is any prescription that's dispensed for a short-term condition.

Skilled Nursing Service

Those services provided by a registered nurse (R.N.) or licensed practical nurse (L.P.N.) which require the clinical skill and professional training of an R.N. or L.P.N. and which cannot reasonably be taught to a person who does not have specialized skill and professional training. Benefits for skilled nursing service will not be provided due to the lack of willing or available non-professional personnel. Skilled nursing service does not include custodial care service.

Specialist

A specialist is a professional provider who is **not** a physician in general practice, family practice, internal medicine, obstetrics, gynecology, or pediatrics.

Speech Therapist

A duly licensed speech therapist.

Speech Therapy

Treatment to correct a speech impairment that results from an illness, trauma, congenital anomaly, or previous therapeutic process. This therapy is designed and adapted to promote the restoration of a useful physical function. It doesn't include educational training or services that are designed and adapted to develop a physical function.

Step Therapy

A form of preauthorization under which certain prescription drugs will be excluded from coverage, unless a first-line therapy drug(s) is used first by you. The list of step-therapy drugs is subject to change by CVS Caremark or an affiliate. An updated copy of the list of drugs subject to step therapy is available upon request by you or may be accessed on the CVS Caremark website at **www.caremark.com**.

Substance Abuse

The uncontrollable or excessive abuse of addictive substances consisting of alcohol, morphine, cocaine, heroin, opium, cannabis, and other barbiturates, amphetamines, tranquilizers and/or hallucinogens, and the resultant physiological and/or psychological dependency which develops with continued use of such addictive substances requiring Medical Care as determined by a *behavioral health provider*.

Substance Abuse Rehabilitation Treatment

An organized, intensive, structured, rehabilitative treatment program of either a Hospital or Substance Abuse Treatment Facility. It does not include programs consisting primarily of counseling by individuals other than a *behavioral health provider*, court ordered evaluations, programs which are primarily for diagnostic evaluations, mental retardation or learning disabilities, care in lieu of detention or correctional placement or family retreats.

Substance Abuse Treatment Facility

A facility (other than a Hospital) whose primary function is the treatment of substance abuse and is licensed by the appropriate state and local authority to provide such service. It does not include half-way houses, boarding houses, or other facilities that provide primarily a supportive environment, even if counseling is provided in such facilities.

An “administrator substance abuse treatment facility” means a substance abuse treatment facility which has a written agreement with the claims administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered to you.

A “non-administrator substance abuse treatment facility” means a substance abuse treatment facility that does not meet the definition of an administrator substance abuse treatment facility.

Surgery

Means the performance of any medically recognized, non-investigational surgical procedure—including the use of specialized instrumentation and the correction of fractures or complete dislocations and any other procedures as reasonably approved by the claims administrator.

Surgery Center

An appropriately licensed provider, with an organized staff of physicians, that meets all of the following criteria:

- Has permanent facilities and equipment for the primary purpose of performing surgical procedures on an outpatient basis;
- Provides treatment by or under the supervision of physicians and nursing services whenever the patient is in the facility;
- Does not provide inpatient accommodations; and
- Is not a facility used primarily as an office or clinic for the private practice of a physician or other provider.

Ambulatory surgical facility is a place that furnishes the space, equipment, technical support, Clinical staff and/or supplies and specializes in providing surgery, including certain pain management and Diagnostic (i.e., colonoscopy) Services in an Outpatient setting. Also referred to as Ambulatory Surgical Center.

Temporomandibular Joint Dysfunction and Related Disorders

Jaw joint conditions including temporomandibular joint disorders and craniomandibular disorders, and all other conditions of the joint linking the jaw bone and skull and the complex of muscles, nerves and other tissues relating to that joint.

Terminally Ill (Hospice Care)

The Plan considers a patient to be terminally ill if he or she has a prognosis of six months or less to live (as diagnosed by a physician).

Therapeutic Drug Class

A group of drugs or medications that have similar or identical mode of actions or exhibit similar or identical outcomes for treating a disease or injury.

Totally Disabled

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

Uniformed Services

Means the performance of duty on a voluntary or involuntary basis under competent authority within the Armed Forces, the Army National Guard, and the Air National Guard, including active duty, inactive duty for training, initial active duty for training, inactive duty training, and a period during which an individual is absent from employment with the Company for the purpose of an examination to determine his or her fitness to perform such duty. Uniformed service also includes service in the commissioned corps of the Public Health Service and any other category of person designated by the President of the United States in time of war or emergency. In addition, certain types of service in the National Disaster Medical System are considered to be uniformed service covered by USERRA.

Valid Claim

A communication for you or your covered dependent (“claimant”) constitutes a valid claim if it's in writing on the appropriate claim form (or in such other manner acceptable to the claims administrator) and is delivered (along with any supporting comments, documents, records, and other information) to the claims administrator by first-class mail or any other acceptable means, to the address for the claims administrator. If a claimant fails to properly file a claim for a benefit under the Plan, he or she will be considered not to have exhausted all administrative remedies under the Plan. This will result in his or her inability to bring a legal action for that benefit. Claims and appeals of denied claims may be pursued by a claimant or, if approved by the claims administrator, his or her authorized representative. See the “Administrative Information” main section for details.

Year of Service

The 12-consecutive-month period of time during which you work as an employee for the Company.