Medical Plan
Summary Plan Description (SPD)
for the
Wolters Kluwer United States Inc.
Group Health & Welfare Benefits Plan

Effective January 1, 2024

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. Group Health & Welfare Benefits Plan (the "Welfare Plan") is an important part of your Wolters Kluwer United States Inc. ("WKUS" or "Company") benefits.

The Welfare 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"). This booklet is your Summary Plan Description ("SPD") for the Blue Cross Blue Shield National coverage options (referred to as the "Plan" throughout this booklet). It describes the basic features of the medical coverages under the Plan (as of January 1, 2024) and how benefits are paid under those options. These are self-insured coverages, which means benefits are paid from the general assets of WKUS. Blue Cross Blue Shield provides certain administrative services for these options, such as *claims* processing. CVS Caremark administers prescription drug coverage for participants in the medical options. In addition, certain terms are italicized throughout this booklet. These terms are further defined within the "Glossary" main section.

Note: This material doesn't describe HMO coverage. Refer to the specific HMO booklet for a summary of benefits provided through that coverage option.

This SPD is written to comply with disclosure requirements under the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). 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. 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 Company or another authorized party, 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*.

Part of the Welfare Plan

The Plan and the SPD describe the medical benefits that are provided through the Welfare Plan. The Plan is one component of the Welfare Plan. The Welfare Plan offers many different types of benefits, including dental and vision coverage, life and accident insurance, long-term disability insurance, employee assistance coverage, and flexible spending accounts. General information regarding the rules for eligibility, enrollment, termination of coverage, and other general Welfare Plan provisions that apply to all benefits provided through the Welfare Plan (including the medical benefits provided through the Plan) are set forth in the Welfare Plan Summary that you received from WKUS. This booklet, together with the Welfare Plan Summary, is your Summary Plan Description ("SPD") for the Plan. You and your beneficiaries may obtain copies of the Welfare Plan and its related documents or examine these documents by contacting the Plan Administrator at the number and address set forth in the "Additional Information" section of the Welfare Plan Summary.

Amendment and Termination

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

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.

No Surprises Act Provisions

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

What is “balance billing” (sometimes called “surprise billing”)?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn’t in your health plan’s network.

Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called “balance billing.” This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

“Surprise billing” is an unexpected balance bill. This can happen when you can’t control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for:

Emergency services

If you have an emergency medical condition and get emergency medical care from an out-of-network provider or facility, the most the provider or facility may bill you is the Plan’s in-network cost-sharing amount (such as copayments and coinsurance). You can’t be balance billed for these emergency services. This includes services you may get after you’re in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical facility

When you get services from an in-network hospital or ambulatory surgical facility, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan’s in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers can’t balance bill you and may not ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers can’t balance bill you, unless you give written consent and give up your protections.

You’re never required to give up your protections from balance billing. You also aren’t required to get care out-of-network. You can choose a provider or facility in your plan’s network.

When balance billing isn’t allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). The Plan will pay out-of-network providers and facilities directly.

- Your health plan generally must:

    - Cover emergency services without requiring you to get approval for services in advance (prior authorization).
    - Cover emergency services by out-of-network providers.
    - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
    - Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you've been wrongly billed, you may 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).

Visit the Your Benefits Resources website at http://www.yourbenefitsresources.com/wolters_kluwer/ for more information about your rights under federal law.

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	

* The Plan pays benefits for eligible expenses. For out-of-network care, eligible expenses are based on the maximum allowance. Except for No Surprises Act Billing Claims, 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	$1,600	$3,200
• Employee + Spouse or Employee + Child(ren)	$3,200	$6,400
• Family[±]	$3,200	$6,400
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 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 members' 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 members' 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)	Unlimited 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; care through 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)
• 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)
• 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	

* The Plan pays benefits for eligible expenses. For out-of-network care, eligible expenses are based on the maximum allowance. Except for No Surprises Act Billing Claims, 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)***
Maximum Benefits	**Plan Pays Benefits For ...**	
• 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	$1,600/$3,200/$3,200	90% of Negotiated Fees (after deductible)	$3,200/$6,400/$6,400	70% of Maximum Allowance (after deductible)
• Physician Services While Hospitalized	$1,600/$3,200/$3,200	90% of Negotiated Fees (after deductible)	$3,200/$6,400/$6,400	70% of Maximum Allowance (after deductible)
• Routine Nursery Care	$1,600/$3,200/$3,200	90% of Negotiated Fees (after deductible)	$3,200/$6,400/$6,400	70% of Maximum Allowance (after deductible)
• Prescription Drugs While Hospitalized and Other Inpatient Care	$1,600/$3,200/$3,200	90% of Negotiated Fees (after deductible)	$3,200/$6,400/$6,400	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	$1,600/$3,200/$3,200	90% of Negotiated Fees (after deductible)	$3,200/$6,400/$6,400	70% of Maximum Allowance (after deductible)
• Private-Duty Nursing Care	$1,600/$3,200/$3,200	90% of Negotiated Fees (after deductible)	$3,200/$6,400/$6,400	70% of Maximum Allowance (after deductible)
• Hospice Care	$1,600/$3,200/$3,200	90% of Negotiated Fees (after deductible)	$3,200/$6,400/$6,400	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. Except for No Surprises Act Billing Claims, 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	$1,600/$3,200/$3,200	90% of Negotiated Fees (after deductible)	$3,200/$6,400/$6,400	70% of Maximum Allowance (after deductible)
• Hospice Care	$1,600/$3,200/$3,200	90% of Negotiated Fees (after deductible)	$3,200/$6,400/$6,400	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)	$1,600/$3,200/$3,200	90% of Negotiated Fees (after deductible)	$3,200/$6,400/$6,400	70% of Maximum Allowance (after deductible)
• Outpatient Surgical Expenses (surgeon's charges and office visits)	$1,600/$3,000/$3,200	90% of Negotiated Fees (after deductible)	$3,200/$6,400/$6,400	70% of Maximum Allowance (after deductible)
• Oral Surgical Procedures (when medical in nature only, impacted teeth not covered)	$1,600/$3,200/$3,200	90% of Negotiated Fees (after deductible)	$3,200/$6,400/$6,400	70% of Maximum Allowance (after deductible)
• Second Surgical Opinions	$1,600/$3,200/$3,200	90% of Negotiated Fees (after deductible)	$3,200/$6,400/$6,400	70% of Maximum Allowance (after deductible)
• Preoperative Testing	$1,600/$3,200/$3,200	90% of Negotiated Fees (after deductible)	$3,200/$6,400/$6,400	70% of Maximum Allowance (after deductible)
Emergency Medical Care Services				
• Hospital Emergency Room	$1,600/$3,200/$3,200	90% of Negotiated Fees	$3,200/$6,400/$6,400	90% of Maximum Allowance

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** 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)**
		(after deductible) If a True Emergency Non-Emergency Use Not Covered		(after deductible) If a True Emergency Non-Emergency Use Not Covered
• Urgent Care Facility	$1,600/$3,200/$3,200	90% of Negotiated Fees (after deductible) If a True Emergency Non-Emergency Use Not Covered	$3,200/$6,400/$6,400	90% of Maximum Allowance (after deductible) If a True Emergency Non-Emergency Use Not Covered
• Ambulance Services	$1,600/$3,200/$3,200	90% of Negotiated Fees (after deductible) If a True Emergency Non-Emergency Use Not Covered	$3,200/$6,400/$6,400	90% of Maximum Allowance (after deductible) If a True Emergency Non-Emergency Use Not Covered
Professional Services				
• Physician Office Visits	$1,600/$3,200/$3,200	90% of Negotiated Fees (after deductible)	$3,200/$6,400/$6,400	70% of Maximum Allowance (after deductible)
• Specialist Office Visits/Consultations	$1,600/$3,200/$3,200	90% of Negotiated Fees (after deductible)	$3,200/$6,400/$6,400	70% of Maximum Allowance (after deductible)
• MDLIVE Telehealth Virtual Visit	$1,600/$3,200/$3,200	90% of Negotiated Fees (after deductible)	NA	NA
• Office Visit Associated with Allergy Testing (if not billed as preventive)	$1,600/$3,200/$3,200	90% of Negotiated Fees (after deductible)	$3,200/$6,400/$6,400	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	$1,600/$3,200/$3,200	90% of Negotiated Fees (after deductible)	$3,200/$6,400/$6,400	70% of Maximum Allowance (after deductible)
• Diagnostic X-Ray and Lab Tests (performed as part of an office visit and billed by a physician)	$1,600/$3,200/$3,200	90% of Negotiated Fees (after deductible)	$3,200/$6,400/$6,400	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)	$1,600/$3,200/$3,200	90% of Negotiated Fees (after deductible)	$3,200/$6,400/$6,400	70% of Maximum Allowance (after deductible)
• Complex Imaging Services (e.g., MRA/MRS, MRI, CT scans, and PET scans); **preauthorization required, see "The Managed Care Program" main section**	$1,600/$3,200/$3,200	90% of Negotiated Fees (after deductible)	$3,200/$6,400/$6,400	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. Except for No Surprises Act Billing Claims, 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	$1,600/$3,200/$3,200	90% of Negotiated Fees (after deductible)	$3,200/$6,400/$6,400	70% of Maximum Allowance (after deductible)
• Short-Term Rehabilitation Services from a Physical, Speech, or Occupational Therapist	$1,600/$3,200/$3,200	90% of Negotiated Fees (after deductible)	$3,200/$6,400/$6,400	70% of Maximum Allowance (after deductible)
• Treatment of Spinal Disorders	$1,600/$3,200/$3,200	90% of Negotiated Fees (after deductible)	$3,200/$6,400/$6,400	70% of Maximum Allowance (after deductible)
• Infusion Therapy Performed in the Home, Office, or Outpatient Facility	$1,600/$3,200/$3,200	90% of Negotiated Fees (after deductible)	$3,200/$6,400/$6,400	70% of Maximum Allowance (after deductible)
• Cardiac/Pulmonary Rehabilitation Therapy (based on medical necessity)	$1,600/$3,200/$3,200	90% of Negotiated Fees (after deductible)	$3,200/$6,400/$6,400	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	$1,600/$3,200/$3,200	90% of Negotiated Fees (after deductible)	$3,200/$6,400/$6,400	70% of Maximum Allowance (after deductible)
• All Subsequent Prenatal and Postnatal Visits	$1,600/$3,200/$3,200	90% of Negotiated Fees (after deductible)	$3,200/$6,400/$6,400	70% of Maximum Allowance (after deductible)
• Delivery Charges (including inpatient hospital routine nursery care)	$1,600/$3,200/$3,200	90% of Negotiated Fees (after deductible)	$3,200/$6,400/$6,400	70% of Maximum Allowance (after deductible)
• Freestanding Birthing Centers	$1,600/$3,200/$3,200	90% of Negotiated Fees (after deductible)	$3,200/$6,400/$6,400	70% of Maximum Allowance (after deductible)

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** 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)**
Family Planning				
• Infertility Treatments (including the diagnosis and treatment of the underlying cause of infertility only)	$1,600/$3,200/$3,200	90% of Negotiated Fees (after deductible)	$3,200/$6,400/$6,400	70% of Maximum Allowance (after deductible)
• Office Visit Associated with Contraceptives, Implants, Devices, and Injectables	$1,600/$3,200/$3,200	90% of Negotiated Fees (after deductible)	$3,200/$6,400/$6,400	70% of Maximum Allowance (after deductible)
• Voluntary Abortions	$1,600/$3,200/$3,200	90% of Negotiated Fees (after deductible)	$3,200/$6,400/$6,400	70% of Maximum Allowance (after deductible)
• Voluntary Sterilization	$1,600/$3,200/$3,200	90% of Negotiated Fees (after deductible)	$3,200/$6,400/$6,400	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 (after deductible)	$3,200/$6,400/$6,400	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 (after deductible)	$3,200/$6,400/$6,400	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 (after deductible)	$3,200/$6,400/$6,400	70% of Maximum Allowance (after deductible)
• Routine Mammograms	None (does not apply to HSA)	100% of Negotiated Fees (after deductible)	$3,200/$6,400/$6,400	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 (after deductible)	$3,200/$6,400/$6,400	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 (after deductible)	$3,200/$6,400/$6,400	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)**
• Hearing Exams (routine only)	None (does not apply to HSA)	100% of Negotiated Fees (after deductible)	$3,200/$6,400/$6,400	70% of Maximum Allowance (after deductible)
• Routine Wellness Screenings	None (does not apply to HSA)	100% of Negotiated Fees (after deductible)	$ $3,200/$6,400/$6,400	70% of Maximum Allowance (after deductible)
Other Covered Services				
• Acupuncture in Lieu of Anesthesia Only	$1,600/$3,200/$3,200	90% of Negotiated Fees (after deductible)	$3,200/$6,400/$6,400	70% of Maximum Allowance (after deductible)
• Allergy Treatments/ Injections (received outside of office visit or not received by a physician)	$1,600/$3,200/$3,200	90% of Negotiated Fees (after deductible) (unless office visit charge is waived)	$3,200/$6,400/$6,400	70% of Maximum Allowance (after deductible)
• Anesthetics	$1,600/$3,200/$3,200	90% of Negotiated Fees (after deductible)	$3,200/$6,400/$6,400	70% of Maximum Allowance (after deductible)
• Bariatric Surgery (through Blue Distinction Centers only; **preauthorization required; see "The Managed Care Program" main section**)	$1,600/$3,200/$3,200	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)	$1,600/$3,200/$3,200	90% of Negotiated Fees (after deductible)	$3,200/$6,400/$6,400	70% of Maximum Allowance (after deductible)
• Drugs and Medications (prescribed during an inpatient stay)	$1,600/$3,200/$3,200	90% of Negotiated Fees (after deductible)	$3,200/$6,400/$6,400	70% of Maximum Allowance (after deductible)
• Durable Medical and Surgical Equipment/ Prosthetics	$1,600/$3,200/$3,200	90% of Negotiated Fees (after deductible)	$3,200/$6,400/$6,400	70% of Maximum Allowance (after deductible)
• Hearing Aids for Children with Congenital Defects, Up to Age 19	$1,600/$3,200/$3,200	90% of Negotiated Fees (after deductible)	$3,200/$6,400/$6,400	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)**
• Mastectomy Services	$1,600/$3,200/$3,200	90% of Negotiated Fees (after deductible)	$3,200/$6,400/$6,400	70% of Maximum Allowance (after deductible)
• Transplant Services (coordination by patient with transplant coordinator; care through Blue Distinction Center is required)	$1,600/$3,200/$3,200	100% of Negotiated Fees (after deductible) at Blue Distinction Center	Not Covered	Not Covered
• Diabetic foot orthotics	$1,600/$3,200/$3,200	90% of Negotiated Fees (after deductible)	$3,200/$6,400/$6,400	70% of Maximum Allowance (after deductible)
• Inpatient (including a residential treatment facility)	$1,600/$3,200/$3,200	90% of Negotiated Fees (after deductible)	$3,200/$6,400/$6,400	70% of Maximum Allowance (after deductible)
• Outpatient (including partial hospitalization)	$1,600/$3,200/$3,200	90% of Negotiated Fees (after deductible)	$3,200/$6,400/$6,400	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	
	You Pay	**You Pay**
Annual Deductible		
• 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

* The Plan pays benefits for *eligible expenses*. For *out-of-network care, eligible expenses* are based on the *maximum allowance.* Except for No Surprises Act Billing Claims, you're responsible for any charge that exceeds the maximum allowance.

± 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)***
• 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)
• Services through Blue Distinction Centers are required for bariatric care, but are optional for knee/hip replacement, spine, cardiac care, and rare cancers; however, they provide a higher level of benefit for these care types	80% after deductible Benefits also may be payable for travel and lodging expenses.	No coverage
Lifetime Maximum Benefit	No Limit	

	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)	Unlimited Visits Per Calendar Year (applies to all combined covered network and out-of-network services; limitations may apply)	
• Spinal Disorders (spinal manipulations performed by a(n) 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; care through 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)
• 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)

* The Plan pays benefits for *eligible expenses*. For *out-of-network care, eligible expenses* are based on the *maximum allowance.* Except for No Surprises Act Billing Claims, 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)***
Maximum Benefits	**Plan Pays Benefits For …**	
• 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. Except for No Surprises Act Billing Claims, 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)
Emergency Medical Care Services				

* 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. Except for No Surprises Act Billing Claims, 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)**
• 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 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
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/indepen-dent 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 (e.g., MRA/MRS, MRI, CT scans, and PET scans; **pre-authorization 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. Except for No Surprises Act Billing Claims, 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 from 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. Except for No Surprises Act Billing Claims, 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)
• Freestanding 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 (after 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 (after 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 (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)**
• Routine Mammograms	None (does not apply to HSA)	100% of Negotiated Fees (after 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 (after 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 (after 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 (after 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 (after 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)	$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)
• Bariatric Surgery (through Blue Distinction Centers only; **preauthorization required; see "The**	$4,500/$6,750/$9,000	80% of Negotiated Fees (after deductible) Benefits also may	Not Covered	Not Covered

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)**
Managed Care Program" main section)		be payable for travel and lodging expenses.		
• 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; care through 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)
Behavioral Health and Substance Abuse Treatments (preauthorization required; see "The Managed Care Program" main section)				
• In patient (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)

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 (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, coinsuranc*e, 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*. Except for No Surprises Act Billing Claims, 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)
• Services through Blue Distinction Centers are required for bariatric care, but are optional for knee/hip replacement, spine, cardiac care, and rare cancers; however, they but provide a higher level of benefit for these care types	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)	Unlimited 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	

* The Plan pays benefits for *Eligible Expenses*. For *out-of-network care*, *eligible expenses* are based on *maximum allowance*. Except for No Surprises Act Billing Claims, 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)***
	may apply; care subject to review at 20 visits)	
	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; care through 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. Except for No Surprises Act Billing Claims, 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

* 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. Except for No Surprises Act Billing Claims, 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)**
					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 Office Visit	NA	NA	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)
• Diagnostic X-Ray and Lab Tests (performed as part of an	None	Per-Office-Visit Copay Applies: $20	100% of Negotiated	$1,200/$2,400	60% of Maximum

* 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. Except for No Surprises Act Billing Claims, 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)**
office visit and billed by a physician)		PCP/ $35 Specialist	Fees (after copay)		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, and 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 from 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)
• 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	$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)**
			(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)
• 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)
• Freestanding Birthing Centers	$600/$1,200	None	80% of Negotiated Fees (after deductible)	$1,200/$2,400	60% of Maximum Allowance (after deductible)
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)

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)**
• Office Visit Associated with Contraceptives, Implants, Devices, and Injectables	None	$20 for Initial 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)
• 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) Vision eyewear benefit is through Blue Cross Blue	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)**
Shield Vision Discount Program					
• 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	$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)
• 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)

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)**
• 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)
• Transplant Services (coordination by patient with transplant coordinator; care through 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 (including partial hospitalization)	$600/$1,200 If Billed as an Office Visit, None	None; Unless Billed as an Office Visit,	80% 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)**
		Then Copay Applies	(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. If you're an HMO participant, please refer to the medical coverage details page on the Benefits Booklet or on Your Benefits Resources website. You also can obtain detailed information that describes your HMO coverage directly from your HMO.

Eligibility and Enrollment

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. The details about the Plan's eligibility and enrollment requirements, including when coverage begins and ends, the cost of coverage, changing elections, etc., are set forth in the "Participation" and "Enrollment" sections of the Welfare Plan Summary.

Medicare-Eligible Covered Person

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/or your covered dependent children's Medicare eligibility. In addition, if you, your spouse, and/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 claims 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, 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 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.

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*.

Non-Tobacco User Credit

If you and your covered dependents pledge that you do not use -tobacco products 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.

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 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 for 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 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.

- *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 qualified expenses without penalty.

- The HSA has the potential to cover all medical expenses you may incur during the year. If you don’t use the entirety 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 the bank.

- 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 Blue Cross Blue Shield of Illinois. 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. .

With one of the HSA coverage options, you can:

- Contribute automatically through pre-tax payroll deductions to reduce your taxable income;

- Use your HSA 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.

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.

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, 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** (this number is also included on your ID card).

You can use Blue Cross Blue Shield Customer Service to:

- Preauthorize certain care, including, but not limited to:
    - *Inpatient hospita*l admissions;
    - *Inpatient* behavioral health and substance abuse treatments;
    - *Emergency admissions*;
    - Maternity admissions; and
    - Alternative hospital care (e.g., *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/bcbsil**) 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 that 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 only if medically necessary. 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 Does Not 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.

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* that 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 that 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 that may be legally rendered by them and that 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, 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 are 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, a residential treatment 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 that 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 professional 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 has begun and must relate to the type, amount, frequency, and duration of therapy and indicate the diagnosis and anticipated goals.

Physical Therapy

Benefits will be provided for physical therapy when rendered by a registered professional physical therapist under the supervision of a physician. The therapy must be furnished under a written plan established by a physician and regularly reviewed by the therapist and the physician. The plan must be established before treatment has begun and must relate to the type, amount, frequency, and duration of therapy and indicate the diagnosis and anticipated goals.

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.

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) that 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 include 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 contact 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 and 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 that 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, 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 and those services or supplies would otherwise be covered as described in this SPD if they were 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

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

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(chickenpox), and other immunizations that are 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 that are for the convenience of the patient or physician, 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 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 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 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 and 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 if 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 the 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 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 during 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 that 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 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.

Employee Assistance Program

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

What the Plan Does Not 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 charges that wouldn't have been 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.
- 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, Services and Supplies That Are Not Medically Necessary

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 that 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 and could have been provided in a physician's office, the outpatient department of a hospital or some other setting without adversely affecting the patient's condition.

Examples of hospitalization and other health care services and supplies that are not medically necessary include:

- Hospital admissions for or consisting primarily of observation and/or evaluation that could have been provided safely and adequately in some other setting, e.g., a physician's office or hospital outpatient department.

- Hospital admissions primarily for diagnostic studies (X-ray, laboratory and pathological services and machine diagnostic tests) which could have been provided safely and adequately in some other setting, e.g., a 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 their family members.

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

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.

The fact that your physician may prescribe, order, recommend, approve, or view hospitalization or other health care services and supplies as medically necessary does not make the hospitalization, services or supplies medically necessary and does not mean that the claims administrator will pay the cost of the hospitalization, services, or supplies.

If your claim for benefits is denied on the basis that the services or supplies were not medically necessary, and you disagree with the claims administrator's decision, your plan provides for an appeal of that decision.

Additional information about appeals procedures is set forth in the “Filing an ERISA Claim or Appeal” main section.

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

Other Excluded Supplies and Services

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

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

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

- Services and supplies for any illness or injury occurring on or after your coverage date as a result of war or an act of war.

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

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

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

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

- Custodial care service.

- Long-term care service.

- Respite care service, except as specifically mentioned under the hospice care program.

- Inpatient private-duty nursing service.

- Routine physical examinations, except as specifically mentioned in this benefit booklet.

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

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

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

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

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

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

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

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

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

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

- Routine foot care, except for persons diagnosed with diabetes.

- Treatment of decreased blood flow to the legs with a pneumatic compression device that delivers high-pressure and rapid inflation/deflation cycles or treatment of tissue damage in any location with platelet-rich plasma.

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

- Immunizations, unless otherwise specified in this benefit booklet.

- Maintenance occupational therapy, maintenance physical therapy and maintenance speech therapy, except as specifically mentioned in this benefit booklet.

- Maintenance care.

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

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

- Hearing aids or examinations for the prescription or fitting of hearing aids, except as specifically mentioned in this benefit booklet.

- Hypnotism.

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

- Diagnostic service as part of routine physical examinations or check-ups, premarital examinations, determination of the refractive errors of the eyes, auditory problems, surveys, case finding, research studies, screening, or similar procedures and studies or tests that are investigational, except as specifically mentioned in this benefit booklet.

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

- Wigs (also referred to as cranial prostheses), except as specifically mentioned in this benefit booklet.

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

- Scanning the visible front portion of the eye with computerized ophthalmic diagnostic imaging or measuring the firmness of the front of the eye with corneal hysteresis by air impulse stimulation.

- Testing of blood for measurement of levels of lipoprotein (a); small dense low-density lipoprotein; lipoprotein subclass high resolution; lipoprotein subclass particle numbers; lipoprotein-associated phospholipase, which are fat/protein substances in the blood, and the test may be ordered in people with suspected deposits in the walls of blood vessels; and allergen-specific IgG.

- Testing for measurement levels of collagen cross-links in the urine, which is a test that may be ordered in people with suspected high bone turnover; and amniotic fluid protein during pregnancy in the cervicovaginal fluid, which may be ordered in people suspected to have fluid leaking from around the baby (premature ruptured membranes).

- Nutritional items such as infant formulas, weight-loss supplements, over-the-counter food substitutes, non-prescription vitamins, and herbal supplements, except those specifically named in this benefit booklet.

- Elective abortions.

- Reversals of sterilization.

- Services and supplies rendered or provided for the treatment of infertility including, but not limited to, hospital services, medical care, therapeutic injections, fertility and other drugs, surgery, artificial insemination and all forms of in-vitro fertilization.

- Abdominoplasty.

- Ecological or environmental medicine, diagnosis and/or treatment.

- Education, training and room and board while confined in an institution that is mainly a school or other logical or other institution for training, a place of rest, a place for the aged or a nursing home.

- Herbal medicine and holistic or homeopathic care, including drugs.

- Services, supplies or medical care or treatment given by a member of your and/or your spouse's immediate family (e.g., spouse, child, brother, sister, parent, grandparent).

- Liposuction.

- Nutritional counseling.

- Examinations or treatment ordered by a court in connection with legal proceedings, unless such examinations or treatment qualify as covered services.

- Services by a pastoral counselor.

- Services for a surgical procedure to correct refraction error of the eye, including any confinement, treatment, or services given in connection with or related to surgery.

- Services for or related to the removal of an organ or tissues from a person for transplantation into another person, unless the transplant recipient is a covered person under this Plan and is undergoing a covered transplant.

- Sensitivity training or educational training therapy of treatment for an education requirement.

- Stand-by services required by a physician.

- Care of or treatment of teeth, gums or supporting structures such as, but not limited to periodontal treatment, endodontic services, extractions, implants or any treatment to improve the ability to chew or speak. See medical benefits for limited coverage of oral surgery and dental services.

- Telephone consultations.

- Tobacco dependency, except as specifically mentioned in this benefit booklet.

- Special foods, food supplements, liquid diets, diet plans or any related products.

- Services given by volunteers or persons who do not normally charge for their services.

- Bereavement counseling.

- Charges incurred in excess of any plan maximums.

- Naprapathic services.

- Any related services to a non-covered service. Related services are a) services in preparation for the non-covered service; b) services in connection with providing the non-covered service; c) hospitalization required to perform the non-covered service; or d) services that are usually provided following the non-covered service, such as follow-up care or therapy after surgery.

- Self-administered drugs dispensed by a physician.

- Behavioral health services provided at behavioral modification facilities, boot camps, emotional group academies, military schools, therapeutic boarding schools, wilderness programs, halfway houses, and group homes, except for covered services provided by appropriate providers as defined in this benefit booklet.

- Any of the following applied behavioral analysis ("ABA") related services:

    - Services with a primary diagnosis that is not autism spectrum disorder;

    - Services that are facilitated by a provider that is not properly credentialed. Please see the definition of "Qualified ABA Provider" in the "Glossary" main section;

    - Activities primarily of an educational nature;

    - Shadow or companion services; or

    - Any other services not provided by an appropriately licensed provider in accordance with nationally accepted treatment standards.

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. Trained staff members with clinical backgrounds and registered graduate nurses 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 prior authorization ("preauthorization") requirements. If you don't, or you don't comply with the Program's determinations, financial penalties will 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 whether your specific care requires preauthorization.

Even if you follow the preauthorization requirements, this doesn't guarantee that the Plan will pay for the service. 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 hospital room and board 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 hospital room and board expenses. All other hospital

expenses, up to the excluded amount, are also 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 hospital room and board 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 the 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 within 48 hours to obtain certification. 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, then 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 a length-of-stay review to have more days certified. To do so, call the number on your ID card.

When you call, a consulting registered nurse will collect information from you and/or your physician and pre-certify the necessity of 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 will be referred to the claims administrator's physician for review. If the physician concurs that the proposed admission or service isn't medically necessary, then 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 the 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, 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, are also 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, 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 will 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, then 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 after 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 or 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 the 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 will work closely with you, your family, and your attending physician to determine the appropriate treatment options that best meet your needs. At the same time, Case Management will work to manage health care costs. Your Case Manager will coordinate your treatment program and arrange 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 or 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 specific situation. 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 during times 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 and manage 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 or your physician 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 or 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 the following 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 Nurse Line

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 can also 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 up to 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 manage your condition and/or make lifestyle changes.

The Mental Health Unit

About the Mental Health Unit

The claims administrator's mental health unit was 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 hospita*l 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 Does Not 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; and

- 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 by 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 (or any day of such confinement) may 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 longer 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 certified day.

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.

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 will generally 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 Plan 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">$1,600 (Employee only)

$ $3,000 (Employee and Spouse or Children)

$3,200 (Employee and Family)</td><td>90% after deductible (in-network)

Preventive Medication Therapy List Drugs: 90%, no deductible</td><td rowspan="3">$1,600 (Employee only)

$ $3,000 (Employee and Spouse or Children)

$3,200 (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 generic and 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) $9,000 (Employee and Family)	70% after deductible (in-network) Preventive Medication Therapy List Drugs: 70%, no deductible	$4,500 (Employee Only) $6,750 (Employee and Spouse or Children) $9,000 (Employee and Family)	70% after deductible (in-network) Preventive Medication Therapy List Drugs: 70%, no deductible
Preferred Brand		70% (after deductible) (in-network)		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 generic and 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: $2,500 Family: $5,000			
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 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 the rigorous process ensures 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.

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.

[**] 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 generic and 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.

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 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. A team of registered nurses can also 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.

To provide a comprehensive and cost-effective prescription drug program for you and your family, the Company has contracted to offer the PrudentRx Solution for certain specialty medications. The PrudentRx Solution assists members by helping them enroll in manufacturer copay assistance programs. Medications on the PrudentRx Program Drug List are included in the program and will be subject to a 30% co-insurance, after satisfaction of any applicable deductible. However, if a member is participating in the PrudentRx Solution, which includes enrollment in an available manufacturer copay assistance program for their specialty medication, the member will have a $0 out-of-pocket responsibility for their prescriptions covered under the PrudentRx Solution.

Copay assistance is a process in which drug manufacturers provide financial support to patients by covering all or most of the patient cost share for select medications – in particular, specialty medications. The PrudentRx Solution will assist members in obtaining copay assistance from drug manufacturers to reduce a member's cost share for eligible medications thereby reducing out-of-pocket expenses. Participation in the program requires certain data to be shared with the administrators of these copay assistance programs, but please be assured that this is done in compliance with HIPAA.

If you currently take one or more specialty medications included in the PrudentRx Program Drug List, you will receive a welcome letter from PrudentRx that provides information about the PrudentRx Solution as it pertains to your medication. All eligible members must call PrudentRx at **1-800-578-4403** to register for any manufacturer copay assistance program available for your specialty medication as some manufacturers require you to sign up to take advantage of the copay assistance that they provide for their medications. If you do not call PrudentRx, PrudentRx will reach out to you to assist with questions and enrollment. If you choose to opt out of the PrudentRx Solution, you must call **1-800-578-4403**. Eligible members who fail to enroll in an available manufacturer copay assistance program or who opt out of the PrudentRx Solution will be responsible for the full amount of the 30% co-insurance on specialty medications that are eligible for the PrudentRx Solution.

If you or a covered family member are not currently taking, but will start, a new medication covered under the PrudentRx Solution, you can reach out to PrudentRx or they will proactively contact you so that you can take full advantage of the PrudentRx Solution. PrudentRx can be reached at **1-800-578-4403** to address any questions regarding the PrudentRx Solution.

The PrudentRx Program Drug List may be updated periodically.

Payments made on your behalf, including amounts paid by a manufacturer's copay assistance program, for medications covered under the PrudentRx Solution will not count toward your plan deductible or out-of-pocket maximum (if any), unless otherwise required by law. Also, payments made by you for a medication that does not qualify as an "essential health benefit" under the Affordable Care Act, will not count toward your deductible or out-of-pocket maximum (if any), unless otherwise required by law. A list of specialty medications that are not considered to be "essential health benefits" under the Affordable Care Act is available. An exception process is available for determining whether a medication that is not an "essential health benefit" under the Affordable Care Act is medically necessary for a particular individual.

PrudentRx can be reached at 1-800-578-4403 to address any questions regarding the PrudentRx Solution

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	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 nonparticipating pharmacy, 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

* 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**
	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 pharmacy, the Plan doesn't pay benefits.			long-term medication.
Finding a Pharmacy	You can select a participating pharmacy from the claims administrator's online Directory at www.caremark.com, or you can call **866-587-4797** 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. Using a *formulary*, CVS Caremark can maximize treatment quality, while better managing prescription drug costs.

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, visit 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.

The Retail Pharmacy

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 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 at www.caremark.com, or by calling CVS Caremark at **866-587-4797**. 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.

- 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.

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 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 the medications, medical devices, and other expenses that the Plan covers.

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 Does Not 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.
- Injectable 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:
    - OTC contraceptive supplies (except for women's OTC generic contraceptives with a physician's prescription), including, but not limited to, 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).
- 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* 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).

- Implantable drugs and associated devices.
- *Injectables*, 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;
    - 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, injectables, or supplies provided through a third-party vendor contract with the contract holder.
- 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.
- 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).

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 Employee Assistance Program (EAP)

About the EAP

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 ComPsych Employee Assistant Program. (or "EAP").

The EAP 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 EAP. 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: WKEAP)**

You're not required to make any contributions. The Company pays the full cost of the EAP'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 EAP

As long as you meet the WKUS Health Plan's eligibility requirements, you're eligible for the EAP. The EAP 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 EAP's services. Also, if you continue any coverage through COBRA continuation, you're also eligible to participate.

How the EAP 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 EAP 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, EAP services can help.

The EAP 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 EAP 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 EAP's Services

The EAP 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^{SM} —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, tutorials, streaming videos, and self-assessments
    - “Ask the Expert” personal responses to your questions
    - Childcare, elder care, attorney, and financial planner searches

Confidentiality

When you reach out to the EAP 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. In general, claims for benefits are evaluated by the claims administrator and are subject to ERISA's claims and appeals procedure. By contrast, eligibility claims are not claims for benefits and are evaluated by the Company or its delegates. 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 is unable to resolve the disagreement, there is an appeals procedure in place for you to appeal the denied claims. This section explains the steps you or your authorized representative is required to take to file a claim or appeal.

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.

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 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 for Claims for Benefits

Issues relating to claims for **benefits** under 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:				
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	Not applicable. Response time	5 days	Not applicable. Response time	24 hours

General Procedure	Post-Service Claim	Pre-Service Claim	Concurrent Care Claim	Urgent Care Claim
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.	frame does not begin until claim is properly filed.		frame does not begin until claim is properly filed. If claim involves urgent care, 24 hours.	
When you will be notified of the claim decision: You will be notified of the decision within **(see columns to the right)** of the 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
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 health plan may notify you within **(see columns to the right)** that	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

General Procedure	Post-Service Claim	Pre-Service Claim	Concurrent Care Claim	Urgent Care Claim
additional information is needed. 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. If you provide additional information, you will be notified of the decision by the health plan within **(see columns to right).**	45 days The time period remaining for the initial claim.	45 days The time period remaining for the initial claim.		48 hours 48 hours
How you will be notified of the claim decision: If your claim is approved, 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 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				If your claim is denied, the health plan will notify you by telephone. Within three 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
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.				
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 claims administrator is authorized to finally determine appeals and interpret the terms of the Plan in its sole discretion. All decisions by the claims administrator 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 **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 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.
You should include: • A copy of your claim denial notice. • The reason(s) for the appeal.				

<table>
<tr><th>General Procedure</th><th>Post-Service Claim</th><th>Pre-Service Claim</th><th>Concurrent Care Claim</th><th>Urgent Care Claim</th></tr>
<tr><td colspan="5">

- 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.
</td></tr>
<tr><td>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.</td><td>Benefit appeals:
60 days</td><td>Benefit appeals:
30 days</td><td>Benefit appeals:

Before a reduction or termination of benefits would occur.

If the concurrent claim involves urgent care, 72 hours.</td><td>Benefit appeals:
72 hours</td></tr>
<tr><td colspan="5">

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.
</td></tr>
<tr><td colspan="5">Step 3:</td></tr>
<tr><td colspan="5">

How to proceed if necessary
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's 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.
</td></tr>
</table>

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 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 administrato*r 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 c*laims 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 administrato*r, 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

If a request involving an eligibility issue is denied in whole or in part, you may appeal that decision in writing—along with any supporting comments, documents, records, and other information—by first-class mail postage paid, to the Employee Benefits Department at:

Employee Benefits Department
2700 Lake Cook Road
Riverwoods, IL 60015

If you fail to file a request for review of a denied eligibility issue within the 30-day period following the date of the initial denial, the denial will be final and will not be subject to further appeal under the Plan.

The Employee Benefits Department will make a decision on your appeal as quickly as possible. The decision of the Employee Benefits Department will be final and binding and not subject to further appeal.

EAP Complaints

Should you disagree with a decision made relative to the EAP, 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 and Delegation

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. However, to the extent that the Committee has delegated claims administration authority to a third-party claims administrator (such as Blue Cross Blue Shield), the determination of the third-party claims administrator is final and binding.

Legal Action

After exhaustion and completion of all Plan claims 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).

- **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.

Administrative Information

Administrative Details

The Plan is governed by ERISA. 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. Other important information about the Plan can be found in the "Additional Information" section of the Welfare Plan Summary.

Benefit	Claims Administrator / Insurer (File Claims Here Where Appropriate)	Type of Insurance	Group Number	Contribution
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 Company
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 Company
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 Company
Prescription Drug Coverage—All Blue Cross Blue Shield National Coverage Options	CVS Caremark P.O. Box 52136 Phoenix, Arizona 85072-2136 **1-866-587-4797** **www.caremark.com**	Self-Insured	NA	Employee and Company
Life Resources Program—All Coverage Options	ComPsych Corporation NBC Tower - 13th Floor 455 North Cityfront Plaza Drive Chicago, IL 60611 **1-312-595-4000**	Self-Insured	NA	Employee and Company

Plan Names for Claim Filing Purposes

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. Employee Assistance Program is known as the "EAP" Both the Plan and the EAP are components of the Wolters Kluwer United States Inc. Group Health & Welfare Benefits Plan (the "Welfare Plan").

Source of Contributions and Funding Medium

The EAP 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.

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 EAP. If you have questions about the EAP, you can contact the claims administrator at the following:

ComPsych Corporation
NBC Tower - 13th Floor
455 North Cityfront Plaza Drive
Chicago, IL 60611
1-844-658-1544

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
1-866-587-4797
www.caremark.com

The claims administrator is responsible for making all claims determinations under the Plan. Benefits under this Plan will be paid if the claims administrator decides, in its sole discretion, that the applicant is entitled to them.

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% 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.

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

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**
MDLIVE	MDLIVE Virtual visits (for BCBS National Coverage Options only) **1-888-676-4204** **MDLIVE.com/bcbsil**
WKUS Employee Assistance Program (EAP)	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**
Health Advocate	**Have you contacted the carrier but still need assistance?** Access Health Advocate at **1-866-695-8622**, or online, **HealthAdvocate.com/members.**

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.

Autism Spectrum Disorders

This means pervasive developmental disorders as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, including autism, Asperger's disorder and pervasive developmental disorders not otherwise specified.

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.

Behavioral Health Unit

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

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 toward 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 toward 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 toward a covered service.

Cosmetic

Services that are provided 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 that 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 a 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")

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 issue appeal, you must follow the procedure contained in the "Eligibility Issue Appeals" section above.

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 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.

Freestanding Birthing Center

To qualify, the center 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 postpartum 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;

- During labor, delivery, and the immediate postpartum period, provide for full-time skilled nursing services directed by an R.N. or certified nurse-midwife;

- Provide for, or arrange with a facility in the area to provide for, 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.

Freestanding 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 the 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 stipulates 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. As such, 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 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 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 a 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, a 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.

Long-Term Care Services

Those social services, personal care services and/or custodial care services needed by you when you have lost some capacity for self-care because of a chronic illness, injury, or condition.

Maintenance Care

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/or 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 submitted by nonparticipating 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.

Medically Necessary/Medical Necessity

This means that a specific medical, health care, supply or hospital service is required for the treatment or management of a medical symptom or condition, and that the service, supply or care provided is the most efficient and economical service which can safely be provided.

The fact that your physician may prescribe, order, recommend, approve, or view hospitalization or other health care services and supplies as medically necessary does not make the hospitalization, services or supplies medically necessary and does not mean that the claims administrator will pay the cost of the hospitalization, services, or supplies. Please refer to the “Excluded Expenses Under Blue Cross Blue Shield” section of this booklet for additional information.

The claims administrator will make the initial decision as to whether hospitalization or other health care services or supplies were medically necessary. In most instances this initial 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. In making decisions as to whether the hospitalization or other health care service(s) or supply(ies) is medically necessary (services deemed medically unnecessary are not eligible for payment under the terms of this Plan), the claims administrator will take into account the information submitted to the claims administrator by your provider(s), including any consultations with such providers(s).

Hospitalization or other health care is not medically necessary when, applying the definition of “medically necessary” to the circumstances surrounding the hospitalization or other health care, it is determined that the medical services provided did not require an acute hospital inpatient (overnight) setting but could have been provided in a physician’s office, the outpatient department of a hospital, or some other setting without adversely affecting the patient’s condition.

If your claim for benefits is denied on the basis that the services or supplies were deemed not medically necessary and you disagree with the claims administrator’s initial decision, your benefit program provides for an appeal of that decision. You must exercise your right to this appeal as a precondition to the taking of any further action against the claims administrator, either at law or in equity. To initiate your appeal, you must give the claims administrator written notice of your intention to do so as described in the “Filing and ERISA Claim or Appeal” section of this booklet.

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

1. Hospital admissions for or consisting primarily of observation and/or evaluation that could have been provided safely and adequately in some other setting, e.g., a physician’s office or hospital outpatient department.

2. Hospital admissions primarily for diagnostic studies (X-ray, laboratory and pathological services and machine diagnostic tests) which could have been provided safely and adequately in some other setting, e.g., hospital outpatient department or physician’s office.

3. Continued inpatient hospital care when the patient’s medical symptoms and condition no longer require their continued stay in a hospital.

4. Hospitalization or admission to a skilled nursing facility or residential treatment center, nursing home or other facility for the primary purposes of providing custodial care service, convalescent care, rest cures or domiciliary care to the patient.

5. The use of skilled or private-duty nurses to assist in daily living activities, routine supportive care or to provide services for the convenience of the patient and/or their family members.

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. § 1395y(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 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.

No Surprises Act Billing Claim

No Surprises Act Billing Claims are claims that are subject to the No Surprises Act requirements and include:

- Emergency Services provided by Out-of-Network Providers;
- Covered Services provided by an Out-of-Network Provider at a Network Facility; and
- Out-of-Network Air Ambulance Services.

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, residential treatment center 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 that includes national and regional chain stores. The network also includes many independent pharmacies. To determine whether 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 (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 dependents' ongoing care; and

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), 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 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 ABA Provider

A Provider operating within the scope of their license registration or certification that has met the following requirements:

For the treatment supervisor/case manager/facilitator:

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

(ii) Master's level Clinician whose professional credential is recognized and accepted by an appropriate agency of the United States (i.e., Board-

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Certified Behavior Analyst (BCBA) or Board-Certified Behavior Analyst-Doctoral (BCBA-D) to supervise and provide treatment planning, with ABA service techniques; or

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

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

1. Developmental Therapist with Certified Early Intervention Specialist credential or CEIS; or

2. If the Doctor or Medicine (MD) prescribes ABA, writes a MD order for services to be provided by a specific person.

For the para-professional/line therapist:

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

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

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

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.

Residential Treatment Center

A facility setting offering a defined course of therapeutic intervention and special programming in a controlled environment which also offers a degree of security, supervision, and structure and is licensed by the appropriate state and local authority to provide such service. It does not include halfway houses, supervised living, group homes, wilderness programs, boardinghouses or other facilities that provide primarily a supportive environment and address long-term social needs, even if counseling is provided in such facilities. Patients are medically monitored with 24-hour medical availability and on-site nursing care and supervision for at least one shift a day with on-call availability for other shifts for patients with mental illness and/or substance abuse disorders. Any mental illness and/or substance abuse disorder residential treatment center must be licensed in the state where it is located or accredited by a national organization that is recognized by the claims administrator as set forth in its current credentialing policy, and otherwise must meet all other credentialing requirements set forth in such policy. Residential treatment center programs/services for the treatment of mental illness and/or substance abuse disorders that do not provide 24-hour medical availability and that do not provide on-site nursing care and supervision for at least one shift a day with on-call availability for other shifts are not considered medically necessary.

Respite Care Service

Those services provided at home or in a facility to temporarily relieve the family or other caregivers (nonprofessional 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 regimen 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

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

Substance 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 halfway houses, supervised living, group homes, wilderness programs, boardinghouses, 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 services (i.e., colonoscopy) 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 jawbone 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 modes of action 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 the Uniformed Services Employment and Reemployment Rights Act (“USERRA”).

Valid Claim

A communication for you or your covered dependent (known as a “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 during which you work as an employee for the Company.