2015 Description of Coverage

Prairie State College
01/01/2015

The Managed Care Reform and Patient Rights Act of 1999 established rights for enrollees in health care plans. These rights cover the following:

- What emergency room visits will be paid for by your health care plan.
- How specialists (both in and out of network) can be accessed.
- How to file complaints and appeal health care plan decisions, including external independent reviews.
- How to obtain information about your health care plan, including general information about its financial arrangements with providers.

You are encouraged to review and familiarize yourself with these subjects and the other benefit information in the attached Description of Coverage Worksheet. SINCE THE DESCRIPTION OF COVERAGE IS NOT A LEGAL DOCUMENT, for full benefit information please refer to your contract or certificate, or contact your health care plan at (800) 892-2803. In the event of any inconsistency between your Description of Coverage and contract or certificate, the terms of the contract or certificate will control.

For general assistance or information, please contact the Illinois Department of Insurance, Office of Consumer Health Insurance at (877) 527-9431 or in writing to either of the following addresses:

320 West Washington Street
Springfield, IL 62767-0001

100 West Randolph Street, Suite 15-100
Chicago, IL 60601-3251

You may also contact the department online at http://www.insurance.illinois.gov

(Please be aware that the Office of Consumer Health Insurance will not be able to provide specific plan information. For this type of information you should contact your health care plan directly.)
**Basics** | **Description of Coverage**
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**Your Doctor** | Choose a medical group and primary care physician (PCP) for each member of your family from our directory or Web site. Each female member may select a Woman's Principal Health Care Provider (WPHCP) in addition to her PCP, however your Primary Care Physician and your Woman's Principal Health Care Provider must be affiliated with or employed by your Participating IPA/Participating Medical Group. **All care must be provided or coordinated by your PCP, WPHCP or medical group/Independent Practice Association (IPA).**

| **Annual Deductible** | none |
| **Out-of-Pocket Maximum - Medical** (excludes drugs, vision, durable medical equipment and prosthetics) | Individual $1,500/calendar year |
| | Family $3,000/calendar year |
| **Out-of-Pocket Maximum - Prescription** | Individual $500/calendar year |
| | Family $1,000/calendar year |
| **Lifetime Maximums** | none |
| **Pre-existing Condition Limitations** | none |

| **In the Hospital** | **Description of Coverage** | **Health Care Plan Covers** | **You Pay** |
| **Number of Days of Inpatient Care** | unlimited days | n/a | n/a |
| **Room & Board** | private or semi-private room 100%* | $100 per admission |
| **Surgeon’s Fees** | covered 100%* | $0 |
| **Doctor’s Visits** | covered 100%* | $0 |
| **Medications** | covered 100%* | $0 |
| **Other Miscellaneous Charges** | see exclusions 100%* | $0 |

| **Emergency Care** | **Description of Coverage** | **Health Care Plan Covers** | **You Pay** |
| **Emergency Services** (medical conditions with acute symptoms of sufficient severity such that a prudent layperson could reasonably expect the absence of medical attention to result in serious jeopardy of the person’s health, serious impairment to bodily functions or serious dysfunction to any bodily organ or part) | Covered services performed in a hospital emergency room in or out of area. Copay, if any, waived if admitted. | 100% | $100 |
| **Emergency Post-stabilization Services** covered if approved by PCP | primary care physician 100%* | $30 |
| **Emergency Post-stabilization Services** covered if approved by PCP | specialist 100%* | $50 |

* HMO pays 100 percent of covered charges after member’s copayment, if any, is paid.
# In the Doctor’s Office

<table>
<thead>
<tr>
<th>Description of Coverage</th>
<th>Health Care Plan Covers</th>
<th>You Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctor’s Office Visit (copayment covers the visit and all covered services provided)</td>
<td>100%*</td>
<td>$30</td>
</tr>
<tr>
<td>Specialist</td>
<td>100%*</td>
<td>$50</td>
</tr>
<tr>
<td>Routine Physical Exams</td>
<td>100%*</td>
<td>$0</td>
</tr>
<tr>
<td>Diagnostic Tests and X-rays</td>
<td>100%*</td>
<td>$0</td>
</tr>
<tr>
<td>Immunizations</td>
<td>100%*</td>
<td>$0</td>
</tr>
<tr>
<td>Allergy Treatment &amp; Testing</td>
<td>100%*</td>
<td>$0</td>
</tr>
<tr>
<td>Preventive Health Services</td>
<td>100%*</td>
<td>$0</td>
</tr>
</tbody>
</table>

## Medical Services

<table>
<thead>
<tr>
<th>Description of Coverage</th>
<th>Health Care Plan Covers</th>
<th>You Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient Surgery</td>
<td>hospital facility</td>
<td>100%*</td>
</tr>
<tr>
<td>Maternity Care</td>
<td>Hospital Care</td>
<td>unlimited days</td>
</tr>
<tr>
<td>Physician Care</td>
<td>copay, if any, for 1st visit only</td>
<td>100%*</td>
</tr>
<tr>
<td>Infertility Services</td>
<td>based on your group policy</td>
<td>100%* if covered</td>
</tr>
<tr>
<td>Mental Health &amp; Chemical Dependency Treatment</td>
<td>Outpatient</td>
<td>unlimited visits</td>
</tr>
<tr>
<td>Inpatient</td>
<td>based on your group policy</td>
<td>100%*</td>
</tr>
<tr>
<td>Outpatient Rehabilitation Services (includes, but is not limited to, physical, occupational or speech therapy)</td>
<td>60 combined visits for Occupational Therapy, Physical Therapy and Speech Therapy based on your group policy</td>
<td>100%*</td>
</tr>
<tr>
<td>Outpatient Speech Therapy (for Pervasive Developmental Disorder only)</td>
<td>unlimited visits</td>
<td>100%*</td>
</tr>
</tbody>
</table>

* HMO pays 100 percent of covered charges after member’s copayment, if any, is paid.
### Other Services

<table>
<thead>
<tr>
<th>Other Services</th>
<th>Description of Coverage</th>
<th>Health Care Plan Covers</th>
<th>You Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Durable Medical Equipment</td>
<td>covered</td>
<td>100%*</td>
<td>$0</td>
</tr>
<tr>
<td>Prosthetic Devices</td>
<td>covered</td>
<td>100%*</td>
<td>$0</td>
</tr>
<tr>
<td>Ambulance Service</td>
<td>covered</td>
<td>100%*</td>
<td>$0</td>
</tr>
<tr>
<td>Hospice</td>
<td>covered</td>
<td>100%*</td>
<td>$0</td>
</tr>
<tr>
<td>Coordinated Home Care (excludes custodial care)</td>
<td>covered</td>
<td>100%*</td>
<td>$0</td>
</tr>
</tbody>
</table>

**Prescription Drug** — up to 34 day supply per script

- Generic: 100%* $0
- Formulary Brand: 100%* $10
- Non-formulary Brand: 100%* $40
- Self-injectable: 100%* $10

**Prescription Drug** — up to 90 day supply per script

- Generic: 100%* $20
- Formulary Brand: 100%* $80
- Non-formulary Brand: 100%* $120
- Self-injectable: 100%* $50

**Dental Services**

- Exams: 100%* $0
- Eyewear: based on your group policy

**Vision Care**

- Exams: one every 12 months
- Eyewear: based on your group policy

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*HMO pays 100 percent of covered charges after member’s copayment, if any, is paid.

### Service Area

The BlueCross service area includes the Illinois counties of Boone, Christian, Cook, DeKalb, DuPage, Fulton, Greene, Grundy, Iroquois, Kane, Kankakee, Kendall, Knox, Lake, LaSalle, Lee, Livingston, Logan, Macoupin, Mason, McHenry, Menard, Monroe, Morgan, Ogle, Peoria, Sangamon, Stark, St. Clair, Stephenson, Tazewell, Whiteside, Williamson, Will, Winnebago and Lake county in Indiana. The HMO Illinois service area also includes Kenosha County in Wisconsin. Please note: Some employer groups may have different service areas (see your employer for details) and the service area is subject to change.

### Exclusions and Limitations

To receive benefits, all care must be provided or coordinated by the member's Primary Care Physician (PCP) or Woman's Principal Health Care Provider (WPHCP) or medical group/Independent Practice Association (IPA), except substance abuse/chemical dependency, vision care and hospital emergency care benefits, which are available at contracting providers without a PCP referral.

Below is a summary list of exclusions and limitations. Your plan may have specific exclusions and limitations not included on this list – check Your Health Care Benefit Program Certificate.

#### Exclusions

1. Services or supplies that are not specifically listed in Your Health Care Benefit Program Certificate.
2. Services or supplies that were not ordered by your primary care physician or Woman’s Principal Health Care Provider, except as explained in the Certificate.
3. Services or supplies received before your coverage began or after the date your coverage ended.
4. Services or supplies for which benefits have been paid under any Workers’ Compensation Law or other similar laws. However, this exclusion shall not apply if you are a corporate officer of any business or enterprise, defined as a “small business” under paragraph (b), Section 3 of the Illinois Small Business Purchasing Act, as amended, 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.

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

6. Services or supplies rendered to you as the result of an injury caused by another person to the extent that you have collected damages for such injury and that the Plan has provided benefits for the services or supplies rendered in connection with such injury.

7. Services or supplies that do not meet accepted standards of medical or dental practice including, but not limited to, services which are investigational in nature.

8. Custodial care services.

9. Long Term Care services.

10. Respite Care Services, except as specifically mentioned under Hospice Care Benefits.

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

12. Special education therapy, such as music therapy or recreational therapy, except as stated in your Certificate.

13. Cosmetic surgery and related services and supplies unless correcting congenital deformities or conditions resulting from accidental injuries, tumors or disease.

14. Services or supplies received from a dental or medical department or clinic maintained by an employer, labor union or other similar person or group.

15. 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.

16. Charges for failure to keep a scheduled visit or for completion of a claim form or charges for transferring medical records.

17. Personal hygiene, comfort or convenience items commonly used for purposes that are not medical in nature, such as air conditioners, humidifiers, physical fitness equipment, televisions or telephones.

18. Special braces, splints, specialized equipment, appliances, ambulatory apparatus or battery controlled implants.

19. Prosthetic devices, special appliances or surgical implants unrelated to the treatment of disease or injury, for cosmetic purposes or for the comfort of the patient.

20. Nutritional items such as infant formula, weight-loss supplements, over-the-counter food substitutes and non-prescription vitamins and herbal supplements, except as stated in your Certificate.

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

22. Marriage counseling.

23. Hypnotism.


26. Maintenance occupational therapy, maintenance physical therapy, and maintenance speech therapy, except as stated in your Certificate.
27. Maintenance care.
28. Self-management training, education and medical nutrition therapy.
29. Services or supplies which are rendered for the care, treatment, filling, removal, replacement or artificial restoration of the teeth or structures directly supporting the teeth.
30. Treatment of temporomandibular joint syndrome with intraoral prosthetic devices or any other method which alters vertical dimension or treatment of temporomandibular joint dysfunction not caused by documented organic joint disease or physical trauma.
31. Services or supplies rendered for human organ or tissue transplants, except as stated in the Certificate.
32. Hearing aids, except as stated in the Certificate.
33. Wigs (also referred to as cranial prostheses).
34. Habilitative Services that are solely educational in nature or otherwise paid under State or Federal law for purely educational services.

Limitations
In addition to the exclusions noted, the following limitations apply:

1. Benefits for oral surgery are limited to:
   - surgical removal of completely bony impacted teeth,
   - excision of tumors or cysts from the jaws, cheeks, lips, tongue, roof or floor of the mouth,
   - surgical procedures to correct accidental injuries of the jaws, cheeks, lips, tongue, roof or floor of the mouth,
   - 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 the 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.
2. Benefits for treatment of dental injury due to accident are limited to treatment of sound natural teeth.
3. Benefits for outpatient rehabilitative therapy are limited to therapy which is expected to result in significant improvement within two months in the condition for which it is rendered.
4. Family planning benefits are not available for repeating or reversing sterilization.
5. Benefits for elective abortion are limited to two per lifetime and are not covered under all benefit plans.
6. Benefits for infertility, when covered, will not be provided for the following:
   - Reversal of voluntary sterilization. However, in the event a voluntary sterilization is successfully reversed, benefits will be provided if your diagnosis meets the definition of “infertility”,
   - Services or supplies rendered to a surrogate, except those costs for procedures to obtain eggs, sperm or embryos from you, will be covered if you choose to use a surrogate,
   - selected termination of an embryo in cases where the mother’s life is not in danger,
   - cryo-preservation or storage of sperm, eggs or embryos, except for those procedures which use a cryo-preserved substance
   - non-medical costs of an egg or sperm donor,
   - travel costs for travel within 100 miles of the covered person’s home or which is not medically necessary or which is not required by the plan,
   - infertility treatments which are determined to be investigational, in writing, by the American Society for Reproductive Medicine or American College of Obstetrics and Gynecology, and
   - Infertility treatment rendered to your dependents under the age of 18.
7. Benefits for ambulance service are limited to certified ground ambulance, except for human organ transplants.

8. Human organ transplants must be performed at a plan-approved center for human organ transplants and benefits do not include organ transplants and/or services or supplies rendered in connection with an organ transplant which are investigational as determined by the appropriate technological body; drugs which are investigational; storage fees; services provided to any individual who is not the recipient or actual donor, unless otherwise specified in this provision; cardiac rehabilitation services when not provided to the transplant recipient immediately following discharge from a hospital for transplant surgery; or travel time or related expenses incurred by a provider.

9. Hospice benefits are only available for persons having a life expectancy of one year or less.

10. Prescription drug benefits, when covered, do not include drugs used for cosmetic purposes; any devices or appliances; any charges incurred for administration of drugs; or refills if the prescription is more than one year old.

11. Vision exams are limited to one per 12 month period. Vision coverage does not include benefits for:
   - recreational sunglasses
   - orthoptics, vision training, subnormal vision aids, aniseikonic lenses or tonography
   - additional charges for tinted, photosensitive or anti-reflective lenses beyond the benefit allowance for regular lenses
   - replacement of lenses, frames or contact lenses, which are lost or broken unless such lenses, frames or contact lenses would otherwise be covered according to the benefit period limitations

12. Durable Medical Equipment rental is covered up to the price of purchase.

13. Rehabilitation therapy benefits may be limited – see your Certificate.

14. Maternity inpatient hospital benefits are limited to 48 hours after birth for vaginal deliveries and 96 hours after birth for cesarean deliveries, unless a longer stay is medically necessary.

Pre-certification and Utilization Review
All benefits are provided or coordinated by your PCP or WPHCP. Therefore, certification by the member is not required. Utilization review is conducted by your medical group/IPA, not by the HMO. To ensure fair and consistent decisions regarding medical care, Blue Cross and Blue Shield of Illinois require medical groups/IPAs to use nationally recognized utilization review criteria.

Primary Care Physician (PCP) Selection
Each member must join a contracting medical group/IPA and select a PCP affiliated with that medical group/IPA to provide and coordinate care. Each female member may also choose an OB/GYN to be her Woman’s Principal Health Care Provider (WPHCP), however your Primary Care Physician and your Woman's Principal Health Care Provider must be affiliated with or employed by your Participating IPA/Participating Medical Group. A member has access to her WPHCP as often as needed without a PCP referral. Members may change PCPs/WPHCPs – refer to the Member Handbook or Certificate for instructions and exceptions. Listings of contracting providers are available in the printed HMO directory or online at www.bcbsil.com.

Access to Specialty Care
If clinically appropriate, your PCP or WPHCP will refer you to a specialist, usually within the same medical group as your PCP. If the member’s preferred network specialist does not have a referral arrangement with your PCP/WPHCP, you may choose a new PCP/WPHCP with whom the specialist has such an arrangement. You can ask your PCP for a standing referral for conditions that require ongoing care from a specialist physician. Standing referrals may be made for a specified number of visits or a time period up to one year. Specialist copays may differ, depending on plan design.

Out-of-Area Coverage
When you are out of state, urgent care and hospital emergency room services are available through a...
network of contracting Blue Cross and Blue Shield providers. When you are out of state for a minimum of 90 consecutive days, guest membership may be arranged in participating communities throughout the U.S. with the Guest Membership Coordinator.

Financial Responsibility

You are responsible for copayments at time of service, as shown in the Description of Coverage. You are also responsible for payment for care not provided or coordinated by your PCP or WPHCP, except where otherwise noted. You should contact your employer’s benefit administrator to confirm the level of your contribution to the premium.

Financial Responsibility

Continuity of Treatment

(Transition of Care)

If a physician you are currently obtaining services from leaves the HMO network, you have the right to request transition of care benefits. To qualify for transition of care services, you must currently be undergoing a course of evaluation and/or medical treatment or be in the second or third trimester of pregnancy. The ongoing evaluation and/or medical treatment concerns a condition or disease that requires repeated health care services under a physician’s treatment plan, with the potential for changes in a therapeutic regimen.

Transitional services may be authorized for up to 90 days from the date the physician terminated from the network. Authorization of services depends on the physician’s agreement to comply with contractual requirements and submit a detailed treatment plan, including reimbursement from the HMO at specified rates and adherence to the HMO’s quality assurance requirements, policies and procedures. All care must be transitioned to your new HMO PCP in the medical group/IPA after the transition period has ended. Coverage will be provided only for benefits outlined in your Certificate.

Existing members: Submit a written Transition of Care request within 30 days of receiving notice of the termination of the physician or medical group/IPA.

New members: Submit a written Transition of Care request within 15 days after your eligibility effective date. When submitting the transition of care form prior to your effective date, please include a copy of the signed application and/or confirmation of enrollment with the HMO.

Submit the request to:

Blue Cross and Blue Shield of Illinois
Customer Assistance Unit, Transition of Care
300 East Randolph Street, 23rd Floor
Chicago, IL 60601

Include the following information:
- Policyholder’s name and work/home phone numbers
- Group and ID numbers
- Chosen medical group site
- Chosen PCP name, address and phone/fax numbers
- Current treating physician
- Clinical diagnosis
- Presenting clinical condition (if applicable)
- Reason for transition of care request
- Expected effective date with the HMO or new medical group/IPA (if applicable)

You will be notified within 15 business days of the outcome of your Transition of Care request.

The following provisions are added to your Certificate:

INQUIRIES AND COMPLAINTS

An “Inquiry” is a general request for information regarding claims, benefits, or membership. A “Complaint” is an expression of dissatisfaction by you either orally or in writing. Blue Cross and Blue Shield of Illinois has a team of professionals available to assist you with inquiries and complaints. Issues may include, but are not limited to, the following:
- Claims
- Quality of Care
- Referrals to a Specialist
- Changing your Participating IPA or Participating Medical Group

You may contact Customer Service at the number on the back of your identification card, or you may write to:
Blue Cross and Blue Shield of Illinois
When you contact Customer Service, you will receive a written acknowledgement of your call or correspondence. You will receive a written response to your case within 30 days of receipt by Customer Service. If Blue Cross and Blue Shield of Illinois needs more information, you will be contacted. If a decision will be delayed due to the need for additional information, you will be contacted.

APPEALS
If you submit an inquiry or complaint and it is not resolved to your satisfaction, you may appeal the decision. An appeal is an oral or written request for a review of an adverse decision or action by Blue Cross and Blue Shield of Illinois or its employees. An appeal may be filed by you, a person designated to act on your behalf, or any health care provider. No person reviewing the appeal may have been involved in the initial determination that is the subject of the appeal. If an appeal is not resolved to your satisfaction, you may appeal Blue Cross and Blue Shield of Illinois’ decision to the Department of Insurance. The Department of Insurance will notify Blue Cross and Blue Shield of Illinois of the appeal. Blue Cross and Blue Shield of Illinois will have 21 days to respond to the Department of Insurance.

URGENT/EXPEDITED CLINICAL APPEALS
An urgent/expedited clinical appeal is an appeal of a clinically urgent nature that relates to health care services, including, but not limited to, procedures or treatment ordered by a health care provider that, if a decision is denied, may significantly increase the risk to your health. Upon receipt of an urgent/expedited pre-service or concurrent clinical appeal, Blue Cross and Blue Shield of Illinois will notify the party filing the appeal, as soon as possible, but no more than 24 hours after submission of the appeal, of all the information needed to review the appeal. Additional information must be submitted within 24 hours of request. Blue Cross and Blue Shield of Illinois shall render a determination on the appeal within 24 hours after it receives the requested information.

CLINICAL APPEALS
A clinical appeal is an appeal related to health care services, including, but not limited to, procedures or treatments ordered by a health care provider that does not meet the definition of an urgent/expedited clinical appeal. Upon receipt of a non-urgent pre-service or post-service clinical appeal, Blue Cross and Blue Shield of Illinois will notify the party filing the appeal within three business days if additional information is needed to review the appeal. Additional information must be submitted within five calendar days of the request. Blue Cross and Blue Shield of Illinois shall render a determination on the appeal within 15 business days after it receives the requested information, but in no event more than 30 days after the appeal has been received.

NOTIFICATION
Blue Cross and Blue Shield of Illinois will notify the party filing the appeal, you, and any health care provider who recommended the services involved in the appeal orally of its determination followed-up by a written notice of the determination. The written notification will include:
- A clear and detailed reason for the determination.
- Medical or clinical criteria used in the determination.

Procedures for requesting an external independent review, if your appeal is denied.

EXPEDITED EXTERNAL REVIEW
If you have a medical condition where the timeframe for completion of a.) an expedited internal review of a grievance involving an Adverse Determination; b.) a Final Adverse Determination as set forth in the Managed Care Reform and Patient Rights Act; or, c.) a standard external review as set forth in the Illinois Health Care External Review Act, would seriously jeopardize your life or health or your ability to regain maximum function, then you have the right to have the Adverse Determination or Final Adverse Determination reviewed by an
independent review organization not associated with the Plan. In addition, if a Final Adverse Determination concerns an admission, availability of care, continued stay or health care service for which you received emergency services, but have not been discharged from a facility, then you may request an expedited independent external review.

**STANDARD EXTERNAL REVIEW**
You or your authorized representative must submit a written request for a review within 4 months of receiving a denial of a clinical appeal. Any information or documentation to support your request for the health care services must be included. Within five business days of receipt of your request, BlueCross and BlueShield of Illinois will complete a preliminary review to determine whether:

- you or your dependent was a covered person at the time Covered Services were requested or provided;
- the service that is the subject of the adverse determination or the final adverse determination was a Covered Service under this Certificate;
- you have exhausted Blue Cross and Blue Shield of Illinois’ internal grievance process; and
- you have provided all the information and forms required to process an external review.

For appeals relating to a determination based on treatment being experimental or investigational, Blue Cross and Blue Shield of Illinois will complete a preliminary review to determine whether the requested service or treatment that is the subject of the adverse determination or final adverse determination is a covered Service under this Certificate and that the service or treatment is experimental or investigational for a particular medical condition and is not explicitly listed as an excluded benefit under this Certificate and that your health care provider who ordered or provided the services in question and who is licensed under the Medical Practice Act of 1987, has certified that one of the following situations is applicable:

- standard health care services or treatments are not medically appropriate;
- there is no available standard health care services or treatment covered by Blue Cross and Blue Shield of Illinois that is more beneficial than the recommended or requested service or treatment;
- the health care service or treatment is likely to be more beneficial to you, in the opinion of your health care provider, than any available standard health care services or treatments; or
- that scientifically valid studies using accepted protocols demonstrate that the health care service or treatment requested is likely to be more beneficial to you than any available standard health care services or treatments.

Within one business day after completion of the preliminary review, Blue Cross and Blue Shield of Illinois shall notify you or your designated representative in writing whether the request is complete and is eligible for an external review. If the request is not complete or not eligible for an external review, you shall be notified by Blue Cross and Blue Shield of Illinois in writing of what materials are required or the reason for ineligibility. Within five business days of determining that a request is eligible for an external review, Blue Cross and Blue Shield of Illinois shall a) assign an independent review organization from the list of approved independent review organizations; and b) notify you or your designated representative of the request’s eligibility and acceptance for an external review and the name of the independent review organization. Within five business days upon the assignment of an external independent review organization, Blue Cross and Blue Shield of Illinois or it’s designated utilization review organization, shall provide to the external independent reviewer the documents and any information considered in making the adverse determination or final adverse determination. If Blue Cross and Blue Shield of Illinois fails to provide the documents and information within the above specified time frame, the external independent reviewer may terminate the external review and make a decision to reverse the adverse determination or final adverse determination. The
external independent reviewer shall notify you or your designated representative and BlueCross and Blue Shield of Illinois within three business days of this decision. Within five days after the date of receipt of the necessary information, the external independent reviewer will render a decision based on whether or not the health care services being appealed were medically appropriate and you will receive notification from Blue Cross and Blue Shield of Illinois. If you disagree with the determination of the external independent reviewer, you may contact the Department of Insurance. Benefits will not be provided for services or supplies not covered under your Certificate even if the external independent reviewer determines that the health care services being appealed were medically appropriate.

NON-CLINICAL APPEALS
A non-clinical appeal is an appeal of non-clinical issues, such as appeals pertaining to benefits and administrative procedures. Upon receipt of a pre-service or post-service non-clinical appeal, Blue Cross and Blue Shield of Illinois will notify the party filing the appeal within three business days if additional information is needed to review the appeal. Additional information must be submitted within five calendar days of the request. Blue Cross and Blue Shield of Illinois shall render a decision on the appeal within 15 business days after it receives the requested information.

NOTIFICATION
Blue Cross and Blue Shield of Illinois will notify you and the party filing the non-clinical appeal orally of its determination, followed-up by a written notice of determination. The written notification will include:

- A clear and detailed reason for the determination.
- Contractual, administrative or protocol for the determination. Filing an appeal does not prevent you from filing a complaint with the Department of Insurance or keep from the Department of Insurance investigating a complaint. The Department of Insurance can be contacted at the following addresses:
  - Illinois Department of Insurance
  - Consumer Division
  - 320 West Washington Street
  - Springfield, IL 62767
  - or
  - Illinois Department of Insurance
  - Consumer Division
  - 100 West Randolph Street
  - Suite 15-100
  - Chicago, IL 60601
  In addition, if you have an adverse appeal determination, you may file civil action in a state or federal court.

Members have the right to request information on, the financial relationships between the HMO and any health care provider; the percentage of copayments, deductibles and total premiums spent on health care; and HMO administrative expenses.

For any additional information concerning this Description of Coverage, call the HMO’s toll-free number at (800) 892-2803.

In the event of any inconsistency between your Description of Coverage and contract or certificate, the terms of the contract or Certificate shall control.

A Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association

**This is a general summary of your benefits. Please refer to your Summary of Benefits and Coverage (SBC), or you may request a copy of the policy or plan document by calling Customer Service, for additional details and a description of the plan requirements and benefit design. This plan does not cover all health care expenses. Please carefully review the plan’s limitations and exclusions.**