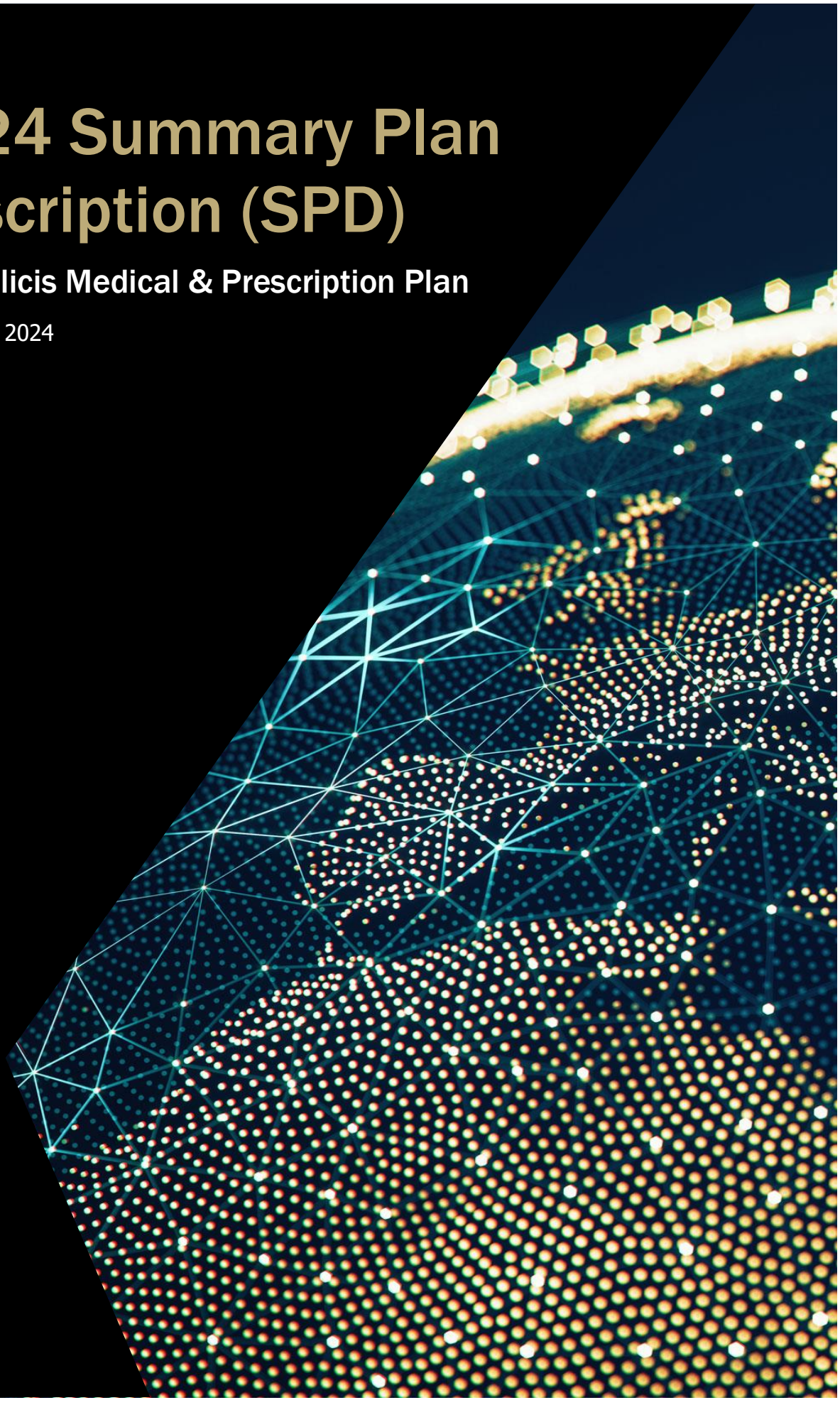
2024 Summary Plan Description (SPD)

for Publicis Medical & Prescription Plan

January 1, 2024



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Your Medical Coverage

Your medical coverage is an important part of your Publicis Connections Health and Group Benefits Program (the "Program") sponsored by the ***Company***. That's why, in many locations, Publicis offers eligible employees and their eligible dependents two Preferred Provider Organization (PPO) options and one High Deductible Health Plan option.

This Summary Plan Description (SPD) together with the Administrative Information Summary Plan Description describes the basic features of the medical coverage under the Plan (referred to as the "Medical Coverage" or "Plan"), how it operates and how you can get the maximum advantage from it. These documents, together with other SPDs of Plan benefits, together with any plan-related document issued by an insurer, constitute a Plan Document and SPD. This document describes the Plan provisions as they exist as of January 1, 2024, while certain other information related to the Plan may be contained in the Administrative Information Summary Plan Description. If any statement, oral or written, made on behalf of the Plan disagrees with this Plan and SPD, as interpreted in the sole discretion of the ***Plan Administrator***, the ***Plan Administrator's*** decision will govern.

Please note that the ***Company*** reserves the right to amend or terminate the Plan at any time without notice. Participation in this Plan does not constitute a contract of employment between you and the ***Company***.

Eligibility

Employee

You are eligible to participate in the Plan if you meet all of the following:

- You are a U.S.-based employee;
- You are a full-time or part-time employee working a minimum regular schedule of at least 21 hours per week;
- You are an employee of a subsidiary of the Company that has adopted the Program; and
- Your class of employees has not been excluded from this or a predecessor plan.
- You are not eligible for coverage under a health plan sponsored by a union pursuant to an agreement or understanding between the Company and a union.
- If you reside in Hawaii, you work at least 20 hours per week and earn 86.67 times the current Hawaii minimum wage a month.

Please contact your local HR Representative or the Publicis Re:Sources USA Benefits Department if you are unsure whether your business unit participates in the Program or if you are a member of an eligible class of employees.

If an individual is not considered to be an "employee" for purposes of employment taxes and wage withholding, a subsequent determination by the employer, any governmental agency, or a court that the individual is a common law employee, if such determination is applicable to prior years, will not have a retroactive effect for purposes of eligibility to participate in the Program.

Your Eligible Dependents

You may elect coverage for your eligible dependents. Your eligible dependents include:

Spouse, your spouse includes the individual to whom you are legally married (determined in accordance with federal law).

Note that under federal law a "common law spouse" will be recognized as a spouse only if relevant state law recognizes the person as a spouse despite the lack of a formal marriage.

You may be required to provide (if requested) a copy of your marriage license.

If you live in a state in which common law marriage is recognized and your "spouse" is your common law spouse under state law, you will be required to prove your marital relationship by providing a copy of a jointly filed federal tax return, or by completing the *Affidavit for Certification of Common Law Marriage* or by providing such other supporting documentation as may be requested by bswift (our benefits administration vendor) to verify eligibility.

Domestic Partners, defined as same-sex and opposite-sex couples registered with any state or local government agency authorized to perform such registrations. If your domestic partnership is not registered with any state or local government agency, your same or opposite sex domestic partner also includes any individual that you have been residing within the same residence for at least six months and who meets the other requirements designated in the Glossary of Terms herein.

If you live in a jurisdiction that offers a domestic partner registry, you will be required to provide upon request, a copy of your domestic partner registration certificate to bswift (our benefits administration vendor) within 30 days of enrollment to verify eligibility for coverage.

If you do not live in a jurisdiction that offers a domestic partner registry or you have not registered, you will be required to complete and submit the *Affidavit for Certification of Domestic Partnership* to bswift (our benefits administration vendor) within 30 days of enrollment to verify eligibility for coverage in order for coverage to begin.

Note: Domestic Partnerships are not recognized by the federal (and most states) government for tax purposes. This means that the value of your domestic partner's coverage will be imputed into your income, as required by tax law, if he or she is not otherwise your dependent under applicable tax law."

Dependent children, include:

- Your natural children or step-children;
- Your legally adopted children;
- Children placed with you for adoption;
- Your foster children;
- Any other children (including grandchildren) for whom you are the legal guardian (as determined by a court of competent jurisdiction); or
- Any children of a *spouse or domestic partner* that must be covered as stipulated by a divorce decree.
- Child(ren) of a domestic partner, not otherwise adopted by you.

Coverage for your dependent child continues (as long as your own coverage continues) until the end of the month in which he or she reaches age 26. If your dependent child is ***totally disabled*** as determined by the Program due to a mental or physical disability and he or she is continuously covered under the Program, coverage may continue beyond age 26 (provided the disability continues and you remain an eligible employee).

When you elect, or do not cancel, coverage for your ***spouse***, ***domestic partner***, or dependent child(ren), you are certifying that they continue to be eligible under these rules. If your ***spouse***, ***domestic partner***, or dependent child(ren) is no longer eligible for coverage, you are expected to contact the Publicis Re:Sources USA Benefits Department as soon as possible to inform them of that fact.

From time to time, the Program will conduct eligibility audits. During an eligibility audit, you will be required to provide documentation substantiating your ***spouse***, ***domestic partner***, or dependent child(ren)'s eligibility in order for them to continue to receive benefits under the Program. The type of documentation that will be accepted will be determined by the ***Plan Administrator*** and communicated to you at the time of the audit.

Divorce Decree

The Program may be required to provide Medical Coverage for your child pursuant to the terms of a divorce decree. This coverage may apply even if you do not have legal custody of the child, the child is not dependent on you for support, and regardless of any enrollment season restrictions that might otherwise exist for dependent coverage. If the ***Company*** receives a valid divorce decree, the Plan may be required to allow you to enroll the dependent child, and if you do not enroll the dependent child, the custodial parent or state agency may enroll the affected child. Additionally, the ***Company*** may withhold from your wages any contributions required for such coverage.

A divorce decree may be either a National Medical Child Support Notice issued by a state child support agency, or an order or a judgment from a state court or administrative body directing the ***Company*** to cover a child under the Program. Federal law provides that a divorce decree 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 may receive a copy of these procedures at no charge. If you have any questions, or would like a copy of the written procedures used to determine whether a divorce decree is valid, please contact the Publicis Re:Sources USA Benefits Department.

Dual Coverage

If your ***spouse*** or ***domestic partner*** works for a participating employer and is eligible for the Program, you have some unique choices to make.

You and your ***spouse*** or ***domestic partner*** may choose "Employee Only" for medical, dental and vision coverage. Or, you may share your coverage if one of you elects ***spouse/domestic partner*** or ***family coverage***.

If one employee chooses to cover his or her ***spouse*** or ***domestic partner*** under his or her plan, the other ***spouse*** or ***domestic partner*** must elect "No Coverage." In addition, children may only be covered as dependents under one parent.

Enrollment

When You First Become Eligible

After your hire date, the Benefits team will upload your information into their system to get you started with enrolling for benefits. You will receive an email or mail notification from bswift—their benefits administrator—when you are able to enroll, and you won't be able to enroll before that notification. You have 45 days from your hire date to enroll. If you do not enroll within this 45-day period (your deadline date is listed on the enrollment worksheet that you receive at your home), you will only receive certain basic coverages provided by the ***Company***, which doesn't include medical coverage.

Here's what you need to do to enroll:

Once you've been notified that you can enroll, review the Health and Group Benefits general information at PublicisConnections.com. Here you'll find everything you need regarding the basics of the benefit offerings.

Once you are familiar with the plan options, which family members you can cover, and how much you'll pay for your coverage during the upcoming plan year, go to **View, Enroll, or Change Your Benefits** to start enrolling. You can enroll 24 hours a day, seven days a week – except for regularly scheduled maintenance between midnight and 6:00 a.m. Eastern Standard Time on Sundays.

Remember to have the following information available for your on-line benefits enrollment:

- The names, dates of birth and social security numbers of your *spouse*, *domestic partner* and/or dependent child(ren) (if you are enrolling them for coverage). If your dependent child is age one or older, you need his or her Social Security number to enroll. If your dependent child does not have a Social Security number, please contact the Benefits Department immediately.

Be sure to click the Submit button to save and submit your elections.

After you submit your elections, a confirmation screen appears with your saved elections. Be sure to review and print this screen for your records. This screen is your confirmation statement. You will also receive an e-mail that your elections have been submitted. The email you receive only acknowledges you have gone out to the Publicis Connections website and made elections. It is not your confirmation statement.

After you review your confirmation statement as described above, you may need to correct your benefit elections. If this is the case, you can do so as many times as necessary within your 45-day election period by accessing the enrollment site and making changes.

Visit the **Guides/Forms** section of the Publicis Connections website if you need to complete any necessary health and group benefits certifications or documents (e.g., domestic partner affidavit) to enroll. The online benefits enrollment prompts you if you need to submit a specific form.

The coverage you elect after you first become eligible continues through the remainder of the ***plan year***, unless you:

- Have a qualified change in status and decide to change your coverage;
- Satisfy the requirements for enrolling under HIPAA special enrollment periods; or
- Cease to be eligible under the Program.

Annual Enrollment

Each fall, you can change your coverage for the following ***plan year***. You will receive information and updates about the Plan so that you can make informed elections during each annual enrollment period.

This information is generally available online on the Publicis Connections website (PublicisConnections.com) and includes:

- Important tips and information on how to enroll for the upcoming *plan year*;
- The benefit options for which you are eligible for the upcoming *plan year*; and
- Any changes that may have taken place since the last annual enrollment period.

You must enroll during annual enrollment unless notified otherwise by the ***Company***. If you want to participate in the Flexible Spending Accounts or the TRIP, you need to reenroll each year. Your contribution elections to the Flexible Spending Accounts do not roll over from one ***plan year*** to the next.

The coverages you elect during the annual enrollment period take effect the following January 1 (or the date you are considered ***actively at work***, whichever is later) and continue through the end of the ***plan year*** (unless you have a qualified change in status and decide to change your coverage, satisfy the requirements under HIPAA for a special enrollment period, or cease to be eligible for the Program).

Enrollment Pursuant to a Divorce Decree

You, a custodial parent, or a state agency may enroll a dependent child pursuant to the terms of a valid divorce decree if the Program is required by law to provide Medical Coverage for your

child pursuant to the terms of a valid divorce decree. A child who is eligible for coverage pursuant to a divorce decree may not enroll dependents for coverage under the Program.

Coverage under the Program is subject to payment of the required contribution unless, in the case of a child who's eligible for coverage pursuant to a divorce decree, payment of the required contribution is made by a state agency. The ***Company*** may withhold from your paycheck any required contributions for this coverage and send the contributions directly to the Program.

If You Do Not Enroll

If you do not enroll when you are newly eligible or during the annual enrollment period, your benefit elections will not rollover into the following plan year and you will only have coverage in the Company-provided benefits such as Basic Life Insurance, Short-Term Disability, Basic Long-Term Disability, and the Employee Assistance Program. The only time your elected benefits will rollover into the next plan year is when the Company indicates that there will be a "passive" enrollment.

ID Cards

Once you enroll, you receive identification cards at your home address.

To receive the highest level of Plan benefits, be sure to show your ID card to your ***provider*** at the time you receive services.

When Coverage Begins

Once you enroll, coverage begins on the first of the month coinciding with or following your hire date or the date you first become eligible to participate in the plan. Your eligible dependents are covered on the same day that your coverage begins.

Paying For Your Coverage

Generally, you pay for your health (medical, dental, and vision) coverage on a pre-tax basis through payroll deductions each pay period. Using pre-tax dollars reduces your taxable income for federal, Social Security and (in most cases) state income taxes. In addition, your income is not affected when determining your benefit levels for coverage under other ***Company***-sponsored Plans.

If you cover a ***domestic partner***, the portion of the premium that you pay that is attributable to your ***domestic partner***'s coverage is paid on a post-tax basis (unless your ***domestic partner*** is your federal tax dependents for group health plan purposes, in which case you must notify the ***Company***). In addition, you will have imputed income for the portion of the ***Company***-paid premium subsidy that is attributable to your ***domestic partner***'s coverage.

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

You and the ***Company*** share the cost of your coverage. The percentage you pay is based on your location/employee group. Please contact the Benefits Department to determine the percentage of premium that you pay on a pre-tax basis. Your annual enrollment materials also contain your cost for this coverage for the upcoming ***plan year***.

Changes in Coverage

Because of the tax advantages associated with certain benefits under the Program, the Internal Revenue Service (IRS) limits your ability to make changes to your benefits after initial enrollment to certain circumstances. These rules govern the types of changes that you may make during the ***plan year***.

In general, once you enroll for (or decline) coverage, your elections stay in effect for the entire ***plan year***. However, under certain circumstances, you may enroll for or change certain coverages during the year. For example, you may change your coverage if:

- You qualify for a special enrollment during the year under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).
- You experience a "qualified change in status" (see below) that affects you, your spouse's or your dependents' eligibility for benefits under the Program.
- The Program receives a Qualified Medical Child Support Order (divorce decree) or other court order, judgment or decree that requires you to enroll a dependent.
- You, your spouse or your dependent qualifies for or loses Medicare or Medicaid coverage.
- You take a leave of absence under the Family and Medical Leave Act (FMLA) (however, you cannot change coverage while you are on FMLA).

There are some additional circumstances under which you may make a mid-year change as described in this section.

Qualified Changes in Status

You may change certain benefit elections during the year if you experience a qualified change in status that results in a loss or gain of eligibility under the Program for yourself, your ***spouse***, your ***domestic partner*** or your eligible dependent children. Changes may be made to your Medical, Dental, Vision, Life, Optional AD&D and Supplemental Long Term Disability coverage as long as the changes are consistent, correspond with the change in status, and follow the Plan's rules. For example, in the case of birth, adoption or placement for adoption, you may increase coverage under your life insurance and enroll your new dependent in the Medical Coverage.

You also may begin or increase contributions to the Health Care Flexible Spending Account and begin, increase, decrease or stop contributions to the Dependent Care Flexible Spending Account if the change is consistent with the change in status.

A qualified change in status is any of the following circumstances that may affect coverage:

You get divorced, legally separated or you have your marriage legally annulled.

Your spouse, domestic partner or dependent dies.

Your dependent child becomes ineligible for eligible coverage (e.g., he or she reaches the Program's eligibility age limit).

You get married.

You have a baby, adopt or have a child placed with you for adoption.

You, your spouse, your domestic partner or your dependent experience a change in employment status (e.g., start or end employment, strike or lockout, begin or return from an

unpaid leave of absence, change work sites or experience a change in employment that leads to a loss or gain of eligibility for coverage).

You, your spouse, your domestic partner or your dependent experiences a change in employment status that affects eligibility for coverage (e.g., change from part-time to full-time or vice versa).

Your, your spouse's, your domestic partner's or your dependent's home address changes (outside the network service area).

You, your spouse, your domestic partner or your dependent experiences a significant change in cost of coverage (this does not apply to the Health Care Flexible Spending Account).

If you experience a qualified change in status and need to change your coverage during the ***plan year***, you must make your change online at PublicisConnections.com within 31 days of the event that necessitates the change. The change will be effective on the date of the qualifying event**.** If you do not make the change in time, you cannot make a coverage change until the next annual enrollment period, unless you once again meet one of the conditions for a mid-year change. Please note that you will be required to provide supporting documentation of your change.

Special Enrollment Rules Under HIPAA

Special enrollment rules apply under the Medical Coverage only due to a loss of other coverage, or a need to enroll because of a new dependent's eligibility.

Special Enrollment Due to Loss of Other Coverage

You and your eligible dependents may be eligible to enroll in Medical Coverage (subject to certain conditions) if you waived your initial coverage at the time it was first offered under this Program because you (or your ***spouse*** or dependent) were covered under another plan or insurance policy. You and your dependents may be eligible to enroll, provided you or your dependents' other coverage was:

- COBRA continuation coverage that has since been exhausted (in other words, you must continue COBRA coverage for the full duration of the COBRA coverage period); or
- Coverage (if not COBRA continuation coverage) that has since terminated due to a "loss of eligibility" or a loss of employer contributions.

"Loss of eligibility" includes a loss of coverage due to:

- Legal separation;
- Divorce;
- Death;
- Termination of employment; or
- Reduction in the number of hours of employment.

It does not include loss of coverage due to failure to timely pay required contributions or premiums, or loss of coverage for cause (i.e., fraud or intentional misrepresentation).

You and your dependents must meet certain other requirements as well.

Required Length of Special Enrollment: You and your dependents must enroll no later than 31 days from the day the other coverage was lost.

Effective Date of Coverage: If you enroll within the 31-day period, coverage takes effect retroactive to the date coverage was lost.

Special Enrollment Due to New Dependent Eligibility

You and your eligible dependents may be eligible to enroll for Medical Coverage under the Program (subject to certain conditions) if you acquire a dependent through marriage, birth, adoption or placement for adoption. The conditions that apply are as follows:

Non-Enrolled Employee: If you are eligible but have not yet enrolled, you may enroll upon your marriage, or upon the birth, adoption or placement for adoption of your child.

Non-Enrolled Spouse: If you are already enrolled, you may enroll your spouse at the time of his or her marriage to you.

New Dependents of an Enrolled Employee: If you are already enrolled, you may enroll a child who becomes your eligible dependent as a result of birth, adoption or placement for adoption.

New Dependents/Spouse of a Non-Enrolled Employee: If you are eligible but not enrolled, you may enroll an individual (spouse or child) who becomes your eligible dependent as a result of marriage, birth, adoption or placement for adoption. However, you (the non-enrolled employee) must also be eligible to enroll and actually enroll at the same time.

Required Length of Special Enrollment: You and your dependents must enroll no later than 31 days from the date of marriage, birth, adoption or placement for adoption.

Effective Date of Coverage: Coverage takes effect retroactive to the date of the gain of dependent eligibility..

Special Enrollment Relating to Medicaid or CHIP

You and your eligible dependents may be eligible to enroll for Medical Coverage (subject to certain conditions) if you previously waived coverage under this Program because you (or your ***spouse*** or dependent) were covered under Medicaid or Children's Health Insurance Program (CHIP) insurance and the Medicaid or CHIP coverage was terminated due to loss of eligibility.

Also, you and your eligible dependents may be eligible to enroll for Medical Coverage (subject to certain conditions) if you previously waived coverage under this Program and you (or your ***spouse*** or dependent) have become eligible for a state premium assistance subsidy under Medicaid or CHIP (note the premium assistance subsidy is not mandatory and each state has its own provisions).

Required Length of Special Enrollment: You and your dependents must enroll no later than 60 days from the day the Medicaid or CHIP eligibility was lost, or from the date you become eligible for the Medicaid or CHIP premium subsidy. (Note: This enrollment period is longer than the enrollment periods shown above for Special Enrollment Due to Loss of Other Coverage and Special Enrollment Due to New Dependent Eligibility.)

Effective Date of Coverage: If you enroll within the 60-day period, coverage takes effect retroactive to the date coverage was lost or the date you become eligible for the premium subsidy.

Additional Mid-Year Changes

You also may change your benefit elections during the year in the following circumstances.

Cost of Coverage Changes

You may be able to change your benefit elections if you experience a significant change in cost of coverage. Under this rule, for example, if you switch from part-time to full-time employment, or vice versa, and, as a result, the cost of your benefits changes significantly, you may be able to change your coverage. You may also be able to revoke your existing elections if your coverage is significantly curtailed (that is, if there is an overall reduction in coverage to all participants), or if a new benefit option is added or eliminated.

Changes to a Spouse's or Dependent's Plan

You may make a mid-year election change that is on account of, and corresponds to, changes made under the plan of your ***spouse***, former ***spouse***, or dependent's employer, or if the other plan has a different ***plan year***, or if the enrollment period is different from the one under this Program.

Automatic Changes

If the cost of your underlying coverage increases or decreases, the ***Company*** may automatically change the amount of your contribution that's withheld. Likewise, the ***Company*** may automatically change the amount of your deduction if it's required to do so by the terms of a divorce decree or by the terms of another judgment, decree or order that requires the Program to provide coverage for your dependents.

Special Rule for Rehired Employees

If you terminate employment and are rehired within 30 days of your termination date, the benefit elections that were in effect on the date of your termination will be automatically reinstated. If you are rehired more than 30 days after the date of your termination, you will be allowed to make new benefit elections under the Program.

Procedure for Mid-Year Changes

You must request a change in your benefit elections within 31 days of the date of the change in status. If a change in status has been experienced, you may alter your benefit options to, among other things, add or drop a dependent, or add or drop coverage for yourself or your ***spouse***. Provided you notify the Program within the required time frames, any changes in your benefit options due to a permissible mid-year event will become effective:

In the case of a dependent's birth, on the date of such birth;

In the case of a dependent's adoption or placement for adoption, on the date of such adoption or placement for adoption; and

For all other events, on the date of the qualifying event.

Note that coverage cannot be paid for retroactively on a pre-tax basis (although it can be retroactively effective) except for in the case of birth, adoption or placement for adoption.

If you experience one of these qualified changes in status, the changes must be consistent with and correspond to the change in status as well as follow Plan rules. For example, in the case of birth, adoption or placement for adoption, you may generally increase coverage under your life insurance and enroll your new dependent for medical or dental coverage, but you cannot drop your current coverage.

If you experience a qualified change in status and need to change your coverage, you must make the change online at PublicisConnections.com, or you must notify the Benefits Department and request assistance with the change. Your change must be made within 31 days (which includes the day the event occurred) of the event that causes the change. If you do not make the change in time, you cannot make a coverage change until the next annual enrollment, unless you once again meet one of the conditions for a mid-year change. If requested, you may have to provide proof of your change in status.

Depending on the reason for the change in status, you may also begin, increase, decrease or stop contributions to the Health Care and Dependent Care Flexible Spending Accounts (if the change is consistent with the change in status).

Coordination of Benefits

If you or your dependents have coverage under another similar plan, your benefits under this Program coordinate with benefits outside the Program to help eliminate duplicate payments for the same services. This section highlights the coordination of benefits (COB) feature.

Coordination Plans

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

Plans or coverage provided by an employer, union, trust or other similar sponsor.

Other group health care plans or coverage that covers you or your dependents, including student coverage provided through a school above the high school level.

Government benefits programs provided or required by law, including Medicare and Medicaid.

Automobile insurance plans in the case of accidents.

These coordination provisions do not apply to individual or private insurance plans.

Any benefits under a plan that covers you or eligible dependents will be considered for possible coordination (even if you do not request payment from them).

How Coordination Works With Other Group Plans

If you are 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 may pay a benefit (if any).

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

If your coverage is secondary, the Plan pays the lesser of:

The Plan's benefit; or

The balance left after the primary plan pays benefits.

When combined, the benefits that the two plans pay will not exceed 100% of the ***eligible expense***.

How Coordination Works With *Medicare*

For a ***Medicare*** eligible individual who is an active employee or the dependent of an active employee, the Plan is generally primary and ***Medicare*** is secondary. Any benefits to which a ***Medicare*** eligible individual may be entitled will be considered by the Plan for possible coordination whether or not the individual actually enrolls in ***Medicare*** Parts A and B. Therefore, the ***Company*** encourages you to apply for coverage under ***Medicare*** as soon as you are eligible. There are certain situations, however, where the Plan will be secondary to ***Medicare*** even for a ***Medicare*** eligible individual who is an active employee or the dependent of an active employee. If you are a ***Medicare*** eligible ***domestic partner*** of a participant, ***Medicare*** will generally be primary and the Plan secondary. Additionally, if you are eligible to continue health care coverage under ***COBRA*** and you become eligible for ***Medicare***, ***Medicare*** may also be primary and the Plan secondary. Generally, that means ***Medicare*** will pay benefits before the Plan pays benefits, if at all. ***Because any benefits to which you may be entitled will be considered by the Plan for possible coordination, the Company encourages you to apply for coverage under Medicare as soon as you are eligible.***

The Prescription Drug Program Benefits offered under the Plan constitute creditable coverage for purposes of ***Medicare*** Part D so you or your ***Medicare***-eligible covered Dependent do not have to enroll in a ***Medicare*** Part D prescription drug program while you are actively employed. Please note, if your ***Medicare***-eligible covered Dependent is your ***domestic partner***, they will have to enroll in a ***Medicare*** Part D prescription drug program while you are actively employed. Also, once you are no longer in active status, you or your ***Medicare***-eligible covered Dependent will be treated as if you have enrolled in a ***Medicare*** Part D prescription drug program, whether you have done so or not.

Medicare Eligible Covered Persons

If you meet the definition of an ***eligible person*** stated in the Eligibility Section above and you are eligible for ***Medicare*** and not affected by the ***Medicare Secondary Payer ("MSP")*** laws as described below, the benefits described in the section of the U.S. Social Security Administration benefit booklet entitled "Benefits for ***Medicare*** Eligible Covered Persons" will apply to you and to your ***spouse*** and covered dependent children (if he or she is also eligible for ***Medicare*** and not affected by the ***MSP*** laws). A series of federal laws collectively referred to as the ***Medicare Secondary Payer ("MSP")*** laws regulate the manner in which certain employers may offer group health care coverage to ***Medicare*** eligible employees, ***spouses***, and in some cases, dependent children.

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

GHPs that cover individuals with end-stage renal disease ("ESRD") during the first 30 months of Medicare eligibility or entitlement. This is the case regardless of the number of employees employed by the employer or whether the individual has "current employment status."

In the case of individuals age 65 or over, GHPs of employers that employ 20 or more employees if that individual or the individual's spouse (of any age) has "current employment status." If the GHP is a multi-employer or multiple employer plan, which has at least one participating employer that employs 20 or more employees, the MSP rules apply even with respect to employers of fewer than 20 employees (unless the plan elects the small employer exception under the statute).

In the case of disabled individuals under age 65, GHPs of employers that employ 100 or more employees, if the individual or a member of the individual's family has "current employee status." If the GHP is a multi-employer or multiple employer plan, which has at least one participating employer that employs 100 or more employees, the MSP rules apply even with respect to employers of fewer than 100 employees.

PLEASE NOTE: SEE YOUR LOCAL HR REPRESENTATIVE OR THE PUBLICIS RE:SOURCES USA BENEFITS DEPARTMENT SHOULD YOU HAVE ANY QUESTIONS REGARDING THE ESRD PRIMARY PERIOD OR OTHER PROVISIONS OF ***MSP*** LAWS AND THEIR APPLICATION TO YOU, YOUR ***SPOUSE*** OR ANY DEPENDENTS.

Your MSP Responsibilities

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 ***Claim Administrator*** and/or the Company regarding the ***Medicare*** eligibility of you, your ***spouse*** and covered dependent children. In addition, if you, your ***spouse*** or covered dependent child becomes eligible

for ***Medicare***, or has ***Medicare*** eligibility terminated or changed, please contact the Company or your group administrator promptly to ensure that your ***claims*** are processed in accordance with applicable ***MSP*** laws.

Determining the Order of Payment

When benefits coordinate, the plans or coverage involved determine which pays benefits first (the primary), second (the secondary), etc. Here are the plan's guidelines for determining which is primary:

If one plan has no Coordination-of-Benefits (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 first.

If both parents' plans cover a dependent, the plans use 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 does not follow the Birthday Rule, then the rules of that plan determine the order of benefits.

In the case of a divorce or separation, the plan relies on the "Birthday Rule" to determine which parent's plan pays first. However, if there's a court order requiring a parent to take financial responsibility for health care coverage for the child, that parent's plan always is primary.

If a determination cannot be made as to the order of payment, the plan that has covered the person longer is usually the primary plan.

Subrogation and Reimbursement

The Program may pay a benefit to you or on behalf of you and/or your dependents in situations where another party was responsible for your or your dependent's illness, injury or other loss. (An example would be a personal injury caused by someone's negligence.) If this is the case, the Program has a right of subrogation as to any funds recovered. In other words, if you or your dependents accept benefits from the Program, you must reimburse the Program in full if you receive payment from any person, entity, organization or their insurers as a recovery for your illness or injury, no matter how that recovery is characterized (medical damages, lost wages, permanent injury damages, etc.).

The Program has the right to a full and complete subrogation of all payment it makes to or on behalf of you and/or your dependents—even if you and/or your dependents are not or will not be fully compensated or made whole by the person or entity providing a recovery related to the injuries or damages. You and/or your dependents must fully cooperate with the Program so that it may exercise its right of subrogation. This may include (but is not limited to) advising the ***Company*** that another party may be responsible for your medical expenses or allowing the Program to pursue legal actions and claims in the name of you and/or your dependents. You and/or your dependents must sign and deliver such documents as this Program or its agents reasonably request to protect this Program's rights of subrogation, equitable lien or constructive trust. You and your dependents must also provide any relevant information and take such actions as this Program or its agents reasonably request to assist this Program in making a full recovery of the reasonable value of benefits provided. You and/or your dependents must not do anything to prejudice the Program's rights of subrogation, equitable lien or constructive trust.

The Program has the right to a full and complete reimbursement from you and/or your dependents, and should be reimbursed for all payments made from any recovery you and/or your

dependents obtain from any insurance company, responsible third party, entity or organization (even if you and/or your dependents have not or will not be fully compensated or made whole for the injuries). In order to secure the rights of the Program, you and/or your dependents hereby: (1) grant to this Program a first priority lien against the proceeds of any settlement, verdict or other amounts received by them or any attorney on behalf of the covered individual; (2) assign to this Program any benefits you and/or your dependents may have under any automobile policy or other coverage, to the extent of this Program's claim for repay; and (3) agree to the imposition of a constructive trust on the proceeds of any settlement, verdict or other amounts received by the covered individual.

In exercising its right of recovery through either subrogation or reimbursement, the Program is not responsible for any fees, expenses, attorneys' fees or representatives' fees that you and/or your dependents may incur to obtain the funds needed to reimburse the Program or pay the Program's subrogation interest. The Program's subrogation claim is paid first out of any recovery obtained.

If a settlement is reached, you must reimburse (in full) the Medical, Dental or Disability benefits paid to you by the Program, before any other expenses are paid (including attorney's fees, up to but not exceeding your settlement amount). If the settlement is less than the benefit paid, you must notify the ***Company*** before you agree to compromise the Program's right to recover the benefits it has advanced you.

If you refuse to reimburse the Program, the Program may recover from you by other means, including offsetting future benefit payments.

Continuation or Termination of Coverage

Your coverage will continue until the end of the month in which you end your employment or cease to be eligible to participate in the plan.

Your dependents' coverage will end on the last day of the month in which (whichever occurs first):

Your coverage ends;

You stop making contributions; or

Your dependent no longer meets the eligibility requirements.

If You Die While Employed

If you die while you are still employed, your contribution for Medical Coverage end on the date death occurs. Your covered dependents are eligible to continue health care coverage under ***COBRA*** for 36 months.

If You Become Disabled

If you become disabled and are eligible to receive disability benefits under the STD program, coverage for you and your dependents in the appropriate benefit plans continues provided you continue to receive STD benefits.

If your disability continues and you start collecting long-term disability benefits from the LTD Plan, your active coverage will terminate the end of the month in which your LTD benefits commence and you and your covered dependents are then eligible to continue coverage under ***COBRA***. Please note that if you become eligible for ***Medicare*** benefits because of your disability, any elected ***COBRA*** coverage will be coordinated with ***Medicare***, *whether or not you enroll in* ***Medicare***. If ***Medicare*** is the primary payor, for instance once you are no longer in active status, the Plan will pay benefits, if at all, only after offsetting any benefits that would be payable by ***Medicare***.

If You Take a Leave of Absence

You may decide to take either an unpaid personal leave or an unpaid FMLA leave of absence.

Unpaid Personal Leave: If you take an unpaid personal leave of absence for 30 days or less, coverage continues for you and your eligible dependents. However, you must submit payment for the full cost of the coverage.

> If your unpaid personal leave of absence is more than 30 days, coverage for you and your dependents ends the first of the month following your 30th day of leave. You and your dependents can continue health care coverage under ***COBRA***. If you return to active employment for the ***Company***, you must reenroll for benefits upon your return.

Unpaid FMLA Leave: If you decide to take an unpaid FMLA leave, coverage continues for you and your eligible dependents as if you were still an active employee. However, you must continue to submit payment for this coverage (at the active rate). You can select a core coverage of health, dental and vision, or you can continue all of your coverages. You may also decide to discontinue your coverage under the Plan.

Continuation of Coverage Under the Family and Medical Leave Act of 1993 (FMLA)

The ***Company*** continues your coverage under the plan during your period of FMLA leave just as if you were still employed. Continued coverage ends once you:

Terminate employment; or

Exhaust your approved period of FMLA leave and do not return from your FMLA leave.

If your employment does not terminate during your leave, but you do not return to work once your leave ends, you can elect to continue health coverage under the ***COBRA*** continuation rules. Your ***COBRA*** continuation period begins on the last day of your FMLA leave.

If you are on an unpaid leave and fail to reimburse the ***Company***, the ***Company*** may recover the value of benefits or premiums paid to maintain your health coverage during your FMLA period of leave.

Continuation of Coverage Under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA)

If you are absent from work because of your service in the ***uniformed services*** (including Reserve and National Guard duty), you may elect to continue health coverage for yourself and your eligible dependents under the provisions of USERRA. The period of coverage for you and your eligible dependents ends on the earlier of:

The end of the 24-month period starting on the day your military leave of absence begins.

The day after the day on which you are required but fail to contact your local HR Representative or the Publicis Re:Sources USA Benefits Department or return to work. Under USERRA, you must contact "the Company" regarding your return to work within different time periods—depending on the duration of your uniformed service:

- If your uniformed service is less than 31 days: You are generally required to return to work on the first full calendar day of the first full scheduled work period following your period of uniformed service. (Your period of uniformed service ends after you return from your place of service to your residence.)
- If your uniformed service is between 31 and 180 days: You are generally required to contact "the Company" regarding your return to work within 14 days of your discharge.
- If your uniformed service is at least 181 days: You are generally required to contact "the Company" regarding your return to work within 90 days of your discharge.

You may be required to pay all or a portion of the cost of your coverage:

- If your military service is 31 days or less: You are required to pay no more than your usual share of the cost for this period of coverage.
- If your military service is more than 31 days: You must pay the entire cost of the coverage (not to exceed 102% of the applicable premium similar to the manner in which the cost for COBRA continuation coverage is calculated).

You must also notify your HR Representative that you'll be absent from employment due to military service (unless you cannot give notice because of military necessity or unless under all relevant circumstances, notice is impossible or unreasonable). You must also notify your HR

Representative that you want to elect continuation coverage for yourself and/or your eligible dependents under the USERRA provisions.

Uniformed services include such military service as:

- Active duty;
- Active duty for training;
- Initial active duty for training;
- Inactive duty for training;
- Full-time National Guard duty; and
- Military fitness examinations.

COBRA

The Consolidated Omnibus Budget Reconciliation Act (***COBRA***) requires the Program to offer you and your dependents the opportunity to pay for a temporary extension of health care coverage in certain situations where your active employee coverage is lost. This section highlights your ***COBRA*** coverage.

When You and/or Your Dependents Elect *COBRA*

COBRA allows you and your dependents to continue the coverage that was in effect on the day that your active employee coverage would have ended. In other words, if you did not have active coverage, you cannot elect ***COBRA***. If coverage under the Program changes while you are on ***COBRA***, your coverage will also change. In addition, you'll have the same annual enrollment benefit choices as Program participants.

If you elect ***COBRA*** coverage, it takes effect on the date your coverage under the Program ended, and continues for up to 18 to 36 months (depending on your situation).

COBRA applies to the medical, dental, vision, and Health Care Spending Account plans.

Snapshot of *COBRA* Continuation Coverage

Below is a snapshot of who is eligible for ***COBRA*** coverage continuation, under what circumstances, and how long ***COBRA*** coverage continuation lasts.

If:	Qualifying Event	Who's Eligible for *COBRA* Coverage	Duration of *COBRA* Coverage*
You	Become laid off	You and your dependents	18 months
	Have a reduction in hours	You and your dependents	18 months
	Terminate employment	You and your dependents	18 months
	Do not return from a leave of absence after 30 days	You and your dependents	18 months
	Begin collecting LTD benefits	You and your dependents	18 months**
	Become disabled within the first 60 days of ***COBRA*** continuation coverage	You and your dependents	29 months
	Die	Your dependents	36 months
	Become divorced or legally separated	Your dependents	36 months
Your Dependent	Is no longer an eligible dependent (due to age limit, divorce or legal separation)	Your dependent	36 months
	Is no longer an eligible dependent because of your death	Your dependent	36 months
	Becomes disabled within the first 60 days of ***COBRA*** continuation coverage	You and your dependent	29 months

*Duration of coverage is from the date of the qualifying event.
You may be eligible for an additional 11 months of ***COBRA* due to an eligible disability.

The ***COBRA*** rights of you and your dependents will be fully detailed in a notice that will be sent to you in connection with your ***COBRA*** event within 14 days after the ***Company*** notifies bswift of the COBRA event.

Medicare and *COBRA* Continuation Coverage

If you become eligible and enroll in ***Medicare*** benefits within 18 months prior to experiencing a ***COBRA*** qualifying event of termination of employment or reduction in hours, the maximum coverage period for your qualified dependents ends the later of 36 months after the date you become eligible and enroll in ***Medicare*** benefits, or 18 months (or 29 months, if there is a disability extension) after the date of your termination of employment or reduction in hours of employment.

Please note, there are several components or "parts" to ***Medicare***. Part A is for hospital expenses. When you apply for and begin receiving Social Security retirement benefits, you are automatically enrolled in ***Medicare*** Part A. Part B is for other medical expenses. Enrollment in ***Medicare*** Part B is generally not automatic. You also have options for Part C ***Medicare*** Advantage Plans and Part D for prescription drug coverage.

If you or any of your covered dependents were eligible for Medicare prior to becoming eligible for *COBRA* continuation coverage or will become eligible for Medicare while on *COBRA* continuation coverage, it is particularly important to review your coverage options. There are limited enrollment periods for certain types of Medicare coverage. You should begin exploring your Medicare options at least 90 days before your Medicare eligibility date in order to avoid potential penalties. <u>Enrollment in Medicare Part B is your responsibility.</u>

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit https://www.medicare.gov/medicare-and-you and https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods.

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Employee Loses Medical, Dental or Vision Plan Coverage

If you lose coverage because of a layoff, reduction in hours, or you begin collecting LTD benefits or terminate employment, ***COBRA*** continuation coverage is available to you and your dependents for up to 18 months from the date of the qualifying event. **bswift, our benefits enrollment vendor,** notifies you and your dependents of your right to continue coverage when you experience a qualifying event. Such an event makes continuation of coverage available. You must then notify **bswift** (within 60 days of the later of the date you receive notice of your ***COBRA*** rights or the date the coverage is lost) of your decision to continue coverage. You can reach **bswift** by calling **1-866-365-2413.**

If you elect coverage within the 60-day period and pay the required premium, your coverage is retroactively reinstated. If you do not elect ***COBRA*** within the initial enrollment period, or if you do not pay the required premium in full, your coverage ends, and you will not be able to reenroll in the future.

Even if you decline ***COBRA***, each of your eligible dependents has an independent right to elect or reject ***COBRA*** coverage. A parent or legal guardian can elect ***COBRA*** on behalf of a minor child.

If you or your covered dependent becomes disabled, as defined by Social Security, during the first 60 days of ***COBRA*** continuation coverage, the disabled beneficiary and each non-disabled ***COBRA*** beneficiary may extend the 18-month continuation period an additional 11 months, up to 29 months. For the 29-month continuation coverage period to apply, you must notify **bswift** at **1-866-365-2413** that you or your covered dependent is disabled within 60 days of the latest of the date of the determination, the date of the qualifying event or the date you would otherwise lose coverage under the plan due to a qualifying event, and before the end of the 18-month period of COBRA continuation coverage.

If, during the initial 18-month period, the Social Security Administration determines that you are no longer disabled, the 11-month extension does not apply. If your disability ends during the 11-month extension period, your ***COBRA*** coverage ends the first day of the month after 30 days have passed since the Social Security Administration's determination (provided the ***COBRA*** period does not exceed 29 months).

Please note that if you become eligible for ***Medicare*** benefits because of your disability, your Plan benefits, including any elected ***COBRA*** coverage, will be coordinated with ***Medicare***, whether or not you enroll in ***Medicare***. If ***Medicare*** is the primary payor, for instance if you are disabled and no longer in active status, the Plan will pay benefits only after offsetting any benefits that would be payable by ***Medicare***.

Employee Loses Health Care Flexible Spending Account Coverage

You may continue your current contributions to the Health Care Flexible Spending account through ***COBRA*** for the remainder of the ***plan year*** in which your active coverage ends. Keep in mind that you'll lose the pre-tax benefit of the Plan by continuing through ***COBRA***. However, you'll be able to continue to submit eligible ***claims*** to the Plan during your ***COBRA*** continuation period so that you can claim contributions that were not paid out prior to your termination of employment.

Dependent Loses Medical, Dental or Vision Plan Coverage

Your covered dependent has the right to continue his or her coverage for up to 36 months from the date of the qualifying event if he or she loses coverage because:

You and your spouse become divorced or legally separated;

He or she is no longer eligible for coverage under the Program (i.e., reaches the age limit);

You become entitled to benefits under Medicare; or

You die.

If any of the above situations occur, notify the *Company* within 31 days of the qualifying event by logging onto the Publicis Connections website (PublicisConnections.com) and following the appropriate prompts. The *Company* will then notify bswift, who will then send out the *COBRA* rights notice. Failure to take appropriate action via the website may result in the loss of *COBRA* rights. bswift in turn, notifies your dependent of his or her *COBRA* enrollment options. Your dependent must elect to continue coverage by notifying **bswift** within 60 days of the later of the date the benefits terminate due to the qualifying event or the date the dependent receives notice of his or her ***COBRA*** rights.

Newborn or Adopted Children

If, during your ***COBRA*** continuation period, you have or adopt a child, you may elect ***COBRA*** for that child. Coverage for the newborn or adopted child continues for the remainder of your 18-month (or 29-month) continuation period, as a qualified ***COBRA*** beneficiary.

Cost of *COBRA* Coverage

If you elect ***COBRA*** continuation, you are responsible for paying the required premium. The cost is 102% (a 2% administrative cost is added to the actual cost of the coverage) of the total premium rate. These costs are reviewed annually and are subject to change. For benefits that are self-insured, the premium rate is based on actuarial data.

You or your dependent(s) will be billed monthly for the coverage(s) you or your dependent(s) elect. Payment is due by the first of the month for which you are buying coverage. If payment is not received within 30 days of that date, the coverage will be cancelled. The first premium payable when you or a dependent initially elects ***COBRA*** coverage, however, is due within 45 days of the coverage election.

How to Apply for *COBRA* Coverage

To enroll in ***COBRA***, contact **bswift at 1-866-365-2413** or the Publicis Re:Sources USA Benefits Department.

If your home address changes while on ***COBRA***, notify your HR Representative or the Publicis Re:Sources USA Benefits Department.

When *COBRA* Coverage Ends

COBRA continues until the earliest of the following:

The end of the 18-month, 29-month or 36-month continuation period.

The date the Company no longer provides health care coverage to any of its employees.

The date a required premium for continuation of group coverage is due and not paid within the required time.

The date you, as the covered employee, cease to be disabled, if continuation coverage is due to your disability.

After you elect COBRA continuation coverage, the date you and your dependents become entitled to Medicare or covered under another group health care plan.

Reimbursement Account Continuation

You may elect to continue coverage under your Health Care Flexible Spending account through ***COBRA*** until the end of the ***plan year*** only if your remaining contributions for the ***plan year*** would be less than the remaining benefits available to you for the ***plan year***.

Health Insurance Marketplace

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

Other Coverage Options

You may also be eligible for Medicaid or Children's Health Insurance Program (CHIP), which, if eligible, may be a coverage option in lieu of COBRA and may cost less than COBRA continuation coverage. You can learn more about these options at: www.healthcare.gov or https://www.healthcare.gov/medicaid-chip/childrens-health-insurance-program/.

Snapshot of the Coverage Options

The ***Company*** offers two types of Blue Cross Blue Shield of Illinois Preferred Provider Organizations (PPO) plans and one High Deductible Health Plan option. All are designed to help you pay for the cost of ***medical care***.

How Your Medical Coverage Works

In this document you'll find a brief overview of your Blue Cross Blue Shield options – the Premier PPO, the Standard PPO and the Health Savings Account.

Blue Cross Blue Shield Preferred Provider Organization (PPO)

Publicis Connections offers two national PPO options and one High Deductible Health Plan with an HSA option – including prescription drug (administered by CVS/Caremark) and ***mental illness/substance use disorder*** – through Blue Cross and Blue Shield of Illinois. Below is a snapshot of your options. See "Your Prescription Drug Coverage" section of this document for details regarding the Plan's benefits for prescription drug services. All percentages shown refer to the percentage of ***eligible expenses*** covered under the Plan and not the total cost of services or supplies you receive. In addition, if you receive care outside of the network, the Plan coverage is based on the ***maximum allowance*** for the service or supply. Note that a listed coverage also may be affected by "Maximum Benefits" summarized in the charts below or the maximums described elsewhere below.

Premier PPO (Option 1)

Type of Service	**In-Network**	**Out-of-Network**
Coinsurance/ **Annual Deductible**	**You Pay**	**You Pay**
Individual	$850	$1,700
Family*	$1,700	$3,400
Annual Out-of-Pocket Maximum (includes deductible)		
Individual	$3,900	$7,800
Family*	$7,800	$15,600
Copayments	**You Pay**	**Plan Pays****
Physician Office Visits	$25 per visit	60% (after deductible)
Chiropractor Services	$40 per visit	60% (after deductible)
Acupuncture	$40 per visit	60% (after deductible)
Wellness Care	$0	60% (after deductible)
Well Child Care (Children)	$0	60% (after deductible)
Fertility Office Visits	$40 per visit	60% (after deductible)

Type of Service	In-Network	Out-of-Network
Outpatient Mental Illness/Substance Use Disorder Physician Treatments	$40 per visit Notification required if it results in ***inpatient*** stay – otherwise $500 non-notification penalty will apply.	60% (after deductible) Notification required if it results in ***inpatient*** stay – otherwise $500 non-notification penalty will apply.
Virtual Visits (Behavioral or Mental Health diagnosis only)	$40 per visit	60% (after deductible)
Type of Service	**In-Network**	**Out-of-Network**
Coinsurance	**Plan Pays**	**Plan Pays****
Emergency Room	80% (no deductible) Notification required if it results in ***inpatient*** stay – otherwise $500 non-notification penalty will apply.	80% (no deductible) Notification required if it results in ***inpatient*** stay – otherwise $500 non-notification penalty will apply.
Inpatient Hospital Services	Notification required if it results in ***inpatient*** stay – otherwise $500 non-notification penalty will apply.	Notification required if it results in ***inpatient*** stay – otherwise $500 non-notification penalty will apply.
‣ ***Hospital***/Facility/Ancillary Services	80% (after deductible)	60% (after deductible)
‣ Physicians Services	80% (after deductible)	60% (after deductible)
‣ Skilled Nursing Facility	80% (after deductible)	60% (after deductible)
‣ Home Health Care	80% (after deductible)	60% (after deductible)
‣ Hospice Care	100% (no deductible)	100% (no deductible)
‣ Therapy (Physical, Occupational and Speech)	80% (after deductible)	60% (after deductible)
‣ Maternity Services	80% (after deductible)	60% (after deductible)
‣ Preadmission Testing	80% (after deductible)	60% (after deductible)
Outpatient Hospital Services		
‣ ***Hospital***/Facility Services	80% (after deductible)	60% (after deductible)
‣ ***Physician*** Services	80% (after deductible)	60% (after deductible)

Type of Service	In-Network	Out-of-Network
‣ Outpatient Therapy	80% (after deductible)	60% (after deductible)
‣ Renal Dialysis Treatments	80% (after deductible)	60% (after deductible)
‣ ***Surgical*** Services	80% (after deductible)	60% (after deductible)
‣ Ambulatory Surgical Facility	80% (after deductible)	60% (after deductible)
‣ Outpatient Diagnostic Services	80% (after deductible)	60% (after deductible)
‣ Cardiac Rehabilitation	80% (after deductible)	60% (after deductible)
Professional Services		
‣ Office Visits	100% (after ***copayment***)	60% (after deductible)
‣ Consultations or ***Medical Care*** Visits	100% (after ***copayment***)	60% (after deductible)
‣ ***Surgical*** Services	80% (after deductible)	60% (after deductible)
‣ Second ***Surgical*** Opinions	100% (after deductible)	60% (after deductible)
Coinsurance	**Plan Pays**	**Plan Pays****
‣ Therapy treatments (radiation, shock therapy and ***chemotherapy***)	80% (after deductible)	60% (after deductible)
‣ Outpatient Physical, Occupational and Speech Therapy	100% (after ***copayment***) if performed in a ***physician's*** office 80% (after deductible) if performed in a ***hospital*** (***physician's*** fees covered at 100%)	60% (after deductible)
‣ Chiropractor Services	100% (after ***copayment***)	60% (after deductible)
‣ Diabetes Management Services	80% (after deductible)	60% (after deductible)

Terms in *bold/italics* are further defined in the Glossary

Type of Service	In-Network	Out-of-Network
Outpatient Emergency Accident Care and Emergency Medical Care (treatment must be received within 72 hours of accident)		
‣ Hospital (outpatient)	80% (no deductible)	80% (no deductible)
‣ Physician	80% (no deductible)	80% (no deductible)
‣ Emergency Room	80% (no deductible)	80% (no deductible)
Wellness (hospital and professional services)		
‣ Wellness Care		
Routine Physical Exams	100%	60% (after deductible)
Immunizations	100%	60% (after deductible)
Routine Diagnostic Tests	100%	60% (after deductible)
Routine Mammograms	100%	60% (after deductible)
Routine Pap Smear Tests	100%	60% (after deductible)
Prostate Tests	100%	60% (after deductible)
Digital Rectal Exams	100%	60% (after deductible)
Colorectal Cancer Screening	100%	60% (after deductible)
‣ Well Child Care (to age 16)	100%	60% (after deductible)
Other Covered Services		
‣ Elective Abortion	80% (after deductible)	60% (after deductible)

Type of Service	In-Network	Out-of-Network
‣ Acupuncture (includes office visit)	100% (after ***copayment***)	60% (after deductible)
‣ Allergy Shots and Surveys	80% (if no office visit is billed)	60% (after deductible)
‣ Ambulance Services	80% (after deductible)	60% (after deductible)
Coinsurance	**Plan Pays**	**Plan Pays****
‣ Blood and Blood Components	80% (after deductible)	60% (after deductible)
‣ Durable Medical Equipment	80% (after deductible)	60% (after deductible)
‣ Foot Orthotics	80% (after deductible)	60% (after deductible)
‣ Human Organ Transplants (when performed in a BCBS-approved program) including: Heart; Lung; Heart/lung; Liver; and Pancreas or pancreas/kidney	80% (after deductible)	Not covered
‣ Human Organ Transplants, including: Cornea; Kidney; Bone marrow; Heart valve; Muscular-skeletal; and Parathyroid	80% (after deductible)	60% (after deductible)
‣ Fertility Coverage	80% (after deductible)	60% (after deductible)
‣ Leg, Back, Arm and Neck Braces	80% (after deductible)	60% (after deductible)

Type of Service	In-Network	Out-of-Network
‣ Mastectomies	80% (after deductible)	60% (after deductible)
‣ Naprapathic Services	100% (after ***copayment***)	60% (after deductible)
‣ Optometric Services	80% (after deductible)	60% (after deductible)
‣ Oxygen and its Administration	80% (after deductible)	60% (after deductible)
‣ Private Duty Nursing Services	80% (after deductible)	60% (after deductible)
‣ Prosthetic Appliances	80% (after deductible)	60% (after deductible)
‣ Elective Sterilization		
Physician	80% (after deductible)	60% (after deductible)
Facility	80% (after deductible)	60% (after deductible)
Coinsurance	**Plan Pays**	**Plan Pays****
‣ Temporomandibular Joint Dysfunction and Related Medical Disorders	80% (after deductible)	60% (after deductible)
‣ Medical Supplies, ***Surgical*** Dressings and Casts	80% (after deductible)	60% (after deductible)
Mental Illness/Substance Use Disorder Treatments		
‣ ***Inpatient*** Facility Services	80% (after deductible)	60% (after deductible)
‣ Inpatient Physician Services	80% (after deductible)	60% (after deductible)
‣ ***Outpatient*** Facility Services	80% (after deductible)	60% (after deductible)
‣ Outpatient Physician Services	$30 *copayment*	60% (after deductible)
‣ Virtual Visits	$30 *copayment*	60% (after deductible)

Terms in *bold/italics* are further defined in the Glossary

Type of Service	In-Network	Out-of-Network
Maximum Benefits†		
Lifetime Maximum (applicable to all covered in-network and out-of-network services)	Unlimited	Unlimited
Inpatient Skilled Nursing Facility	100 days per year	100 days per year
Home Health Care	100 visits per year	100 visits per year
Outpatient Cardiac Rehabilitation Services	36 treatment sessions within a six-month period	36 treatment sessions within a six-month period
Physical Therapy (outpatient)	30 visits per year	30 visits per year
Occupational Therapy (outpatient)	30 visits per year	30 visits per year
Speech Therapy (outpatient)	30 visits per year	30 visits per year
Chiropractor Services (outpatient)	30 visits per year	30 visits per year
Wellness Benefits	None	None
Acupuncture	30 visits per year	30 visits per year
Foot Orthotics	Four per year (hard or soft)	Four per year (hard or soft)
Human Organ Transplant Travel Companion Benefit	$10,000 per lifetime	Not covered
Fertility Coverage[1]	$15,000 per lifetime for artificial reproduction technology (ART) which includes artificial insemination, IVF, ZIFT and GIFT.	$15,000 per lifetime for artificial reproduction technology (ART) which includes artificial insemination, IVF, ZIFT and GIFT.
Autism Spectrum Disorders	Unlimited	Unlimited
Speech Therapy for Pervasive Developmental Disorders	20 visits per year	20 visits per year
Maximum Benefits†		
Naprapathic Services	30 visits per year	30 visits per year

Terms in *bold/italics* are further defined in the Glossary

Type of Service	In-Network	Out-of-Network
Private Duty Nursing Services	15 visits per month	15 visits per month
Temporomandibular Joint Dysfunction and Related Medical Disorders	$2,500 per lifetime	$2,500 per lifetime

* The entire family deductible must be met before the Plan pays benefits. Once an individual's out of pocket is met, eligible services are paid at 100%.

** If you receive care outside the network, the Plan pays benefits based on the ***maximum allowance*** for the service. If you receive care from a ***non-administrator provider***, benefits will be provided at 50% of the ***eligible charge***.

† Maximum benefits shown are combined maximums for in-network and out-of-network services.

[1] *Cryopreservation and Storage service will still be required to follow medical policy language; currently services are not covered per medical policy.*

Standard PPO (Option 2)

Type of Service	In-Network	Out-of-Network
***Coinsurance*/ Annual Deductible**	**You Pay**	**You Pay**
Individual	$1,100	$2,200
Family*	$2,200	$4,400
Annual Out-of-Pocket Maximum (includes deductible)		
Individual	$6,250	$12,500
Family*	$12,500	$25,000
Copayments	**You Pay**	**Plan Pays****
Physician Office Visits	$30 per visit	60% (after deductible)
Chiropractor Services	$45 per visit	60% (after deductible)
Acupuncture	$45 per visit	60% (after deductible)
Wellness Care	$0	60% (after deductible)
Well Child Care (Children)	$0	60% (after deductible)
Fertility Office Visits	$45 per visit	60% (after deductible)

Type of Service	In-Network	Out-of-Network
Outpatient Mental Illness/Substance Use Disorder Physician Treatments	$45 per visit Notification required if it results in ***inpatient*** stay – otherwise $500 non-notification penalty will apply.	60% (after deductible) Notification required if it results in ***inpatient*** stay – otherwise $500 non-notification penalty will apply.
Virtual Visits (Behavioral or Mental Health diagnosis only)	$45 per visit	60% (after deductible)
Type of Service	**In-Network**	**Out-of-Network**
Coinsurance	**Plan Pays**	**Plan Pays****
Emergency Room	80% (no deductible) Notification required if it results in ***inpatient*** stay – otherwise $500 non-notification penalty will apply.	80% (no deductible) Notification required if it results in ***inpatient*** stay – otherwise $500 non-notification penalty will apply.
Inpatient Hospital Services	Notification required if it results in ***inpatient*** stay – otherwise $500 non-notification penalty will apply.	Notification required if it results in ***inpatient*** stay – otherwise $500 non-notification penalty will apply.
‣ ***Hospital***/Facility/Ancillary Services	80% (after deductible)	60% (after deductible)
‣ Physicians Services	80% (after deductible)	60% (after deductible)
‣ Skilled Nursing Facility	80% (after deductible	60% (after deductible)
‣ Home Health Care	80% (after deductible)	60% (after deductible)
‣ Hospice Care	100% (no deductible)	100% (no deductible)
‣ Therapy (Physical, Occupational and Speech)	80% (after deductible)	60% (after deductible)
‣ Maternity Services	80% (after deductible)	60% (after deductible)
‣ Preadmission Testing	80% (after deductible)	60% (after deductible)
Outpatient Hospital Services		
‣ ***Hospital***/Facility Services	80% (after deductible)	60% (after deductible)
‣ ***Physician*** Services	80% (after deductible)	60% (after deductible)
‣ Outpatient Therapy	80% (after deductible)	60% (after deductible)
‣ Renal Dialysis Treatments	80% (after deductible)	60% (after deductible)
‣ ***Surgical*** Services	80% (after deductible)	60% (after deductible)
‣ Ambulatory Surgical Facility	80% (after deductible)	60% (after deductible)
‣ Outpatient Diagnostic Services	80% (after deductible)	60% (after deductible)

Type of Service	In-Network	Out-of-Network
‣ Cardiac Rehabilitation	80% (after deductible)	60% (after deductible)
Professional Services		
‣ Office Visits	100% (after ***copayment***)	60% (after deductible)
‣ Consultations or ***Medical Care*** Visits	100% (after ***copayment***)	60% (after deductible)
‣ ***Surgical*** Services	80% (after deductible)	60% (after deductible)
‣ Second ***Surgical*** Opinions	100% (after deductible)	60% (after deductible)
‣ Outpatient Diagnostic Services	80% (after deductible)	60% (after deductible)
Coinsurance	**Plan Pays**	**Plan Pays****
‣ Therapy treatments (radiation, shock therapy and ***chemotherapy***)	80% (after deductible)	60% (after deductible)
‣ Outpatient Physical, Occupational and Speech Therapy	100% (after ***copayment***) if performed in a ***physician's*** office 80% (after deductible) if performed in a ***hospital*** (***physician's*** fees covered at 100%)	60% (after deductible)
‣ Chiropractor Services	100% (after ***copayment***)	60% (after deductible)
‣ Diabetes Management Services	80% (after deductible)	60% (after deductible)
Outpatient Emergency Accident Care and Emergency Medical Care (treatment must be received within 72 hours of accident)		
‣ Hospital (outpatient)	80% (no deductible)	80% (no deductible)
‣ Physician	80% (no deductible)	80% (no deductible)
‣ Emergency Room	80% (no deductible)	80% (no deductible)
Wellness (hospital and professional services)		
‣ Wellness Care		
Routine Physical Exams	100%	60% (after deductible)
Immunizations	100%	60% (after deductible)
Routine Diagnostic Tests	100%	60% (after deductible)
Routine Mammograms	100%	60% (after deductible)
Routine Pap Smear Tests	100%	60% (after deductible)
Prostate Tests	100%	60% (after deductible)

Type of Service	In-Network	Out-of-Network
Digital Rectal Exams	100%	60% (after deductible)
Colorectal Cancer Screening	100%	60% (after deductible)
‣ Well Child Care (to age 16)	100%	60% (after deductible)
Other Covered Services		
‣ Elective Abortion	80% (after deductible)	60% (after deductible)
‣ Acupuncture (includes office visit)	100% (after ***copayment***)	60% (after deductible)
‣ Allergy Shots and Surveys	80% (if no office visit is billed)	60% (after deductible)
‣ Ambulance Services	80% (after deductible)	60% (after deductible)
Coinsurance	**Plan Pays**	**Plan Pays****
‣ Blood and Blood Components	80% (after deductible)	60% (after deductible)
‣ Durable Medical Equipment	80% (after deductible)	60% (after deductible)
‣ Foot Orthotics	80% (after deductible)	60% (after deductible)
‣ Human Organ Transplants (when performed in a BCBS-approved program) including: Heart; Lung; Heart/lung; Liver; and Pancreas or pancreas/kidney	80% (after deductible)	Not covered
‣ Human Organ Transplants, including: Cornea; Kidney; Bone marrow; Heart valve; Muscular-skeletal; and Parathyroid	80% (after deductible)	60% (after deductible)
‣ Fertility Coverage	80% (after deductible)	60% (after deductible)
‣ Leg, Back, Arm and Neck Braces	80% (after deductible)	60% (after deductible)
‣ Mastectomies	80% (after deductible)	60% (after deductible)

Type of Service	In-Network	Out-of-Network
‣ Naprapathic Services	100% (after ***copayment***)	60% (after deductible)
‣ Optometric Services	80% (after deductible)	60% (after deductible)
‣ Oxygen and its Administration	80% (after deductible)	60% (after deductible)
‣ Private Duty Nursing Services	80% (after deductible)	60% (after deductible)
‣ Prosthetic Appliances	80% (after deductible)	60% (after deductible)
‣ Elective Sterilization		
Physician	80% (after deductible)	60% (after deductible)
Facility	80% (after deductible)	60% (after deductible)
Coinsurance	**Plan Pays**	**Plan Pays****
‣ Temporomandibular Joint Dysfunction and Related Medical Disorders	80% (after deductible)	60% (after deductible)
‣ Medical Supplies, ***Surgical*** Dressings and Casts	80% (after deductible)	60% (after deductible)
Mental Illness/Substance Use Disorder Treatments		
‣ ***Inpatient*** Facility Services	80% (after deductible)	60% (after deductible)
‣ Inpatient Physician Services	80% (after deductible)	60% (after deductible)
‣ ***Outpatient*** Facility Services	80% (after deductible)	60% (after deductible)
‣ Outpatient Physician Services	$45 *copayment*	60% (after deductible)
‣ Virtual Visits	$45 *copayment*	60% (after deductible)
Maximum Benefits†		
Lifetime Maximum (applicable to all covered in-network and out-of-network services)	Unlimited	Unlimited
Inpatient Skilled Nursing Facility	100 days per year	100 days per year
Home Health Care	100 visits per year	100 visits per year
Outpatient Cardiac Rehabilitation Services	36 treatment sessions within a six-month period	36 treatment sessions within a six-month period
Physical Therapy (outpatient)	30 visits per year	30 visits per year

Type of Service	In-Network	Out-of-Network
Occupational Therapy (outpatient)	30 visits per year	30 visits per year
Speech Therapy (outpatient)	30 visits per year	30 visits per year
Chiropractor Services (outpatient)	30 visits per year	30 visits per year
Wellness Benefits	None	None
Acupuncture	30 visits per year	30 visits per year
Foot Orthotics	Four per year (hard or soft)	Four per year (hard or soft)
Human Organ Transplant Travel Companion Benefit	$10,000 per lifetime	Not covered
Fertility Coverage[1]	$15,000 per lifetime for artificial reproduction technology (ART) which includes artificial insemination, IVF, ZIFT and GIFT.	$15,000 per lifetime for artificial reproduction technology (ART) which includes artificial insemination, IVF, ZIFT and GIFT.
Autism Spectrum Disorders	Unlimited	Unlimited
Speech Therapy for Pervasive Developmental Disorder	20 visits per year	20 visits per year
Maximum Benefits†		
Naprapathic Services	30 visits per year	30 visits per year
Private Duty Nursing Services	15 visits per month	15 visits per month
Temporomandibular Joint Dysfunction and Related Medical Disorders	$2,500 per lifetime	$2,500 per lifetime

* The entire family deductible must be met before the Plan pays benefits. Once an individual's out of pocket is met, eligible services are paid at 100%.

** If you receive care outside the network, the Plan pays benefits based on the ***maximum allowance*** for the service. If you receive care from a ***non-administrator provider***, benefits will be provided at 50% of the ***eligible charge***.

† Maximum benefits shown are combined maximums for in-network and out-of-network services.

[1] *Cryopreservation and Storage service will still be required to follow medical policy language; currently services are not covered per medical policy.*

High Deductible Health Plan with Health Savings Account (Option 3)

Type of Service	In-Network	Out-of-Network
Annual Deductible (includes Prescription Drugs)	**You Pay**	**You Pay**
Individual	***$1,650	***$3,300
Family*	***$3,300	***$6,600
Annual Out-of-Pocket Maximum (includes deductible)		
Individual	$6,650	$13,300
Family*	$13,300	$26,600
	You Pay	**Plan Pays****
Physician Office Visits	80% (after deductible)	60% (after deductible)
Chiropractor Services	80% (after deductible)	60% (after deductible)
Acupuncture	80% (after deductible)	60% (after deductible)
Wellness Care	$0	60% (after deductible)
Well Child Care (Children)	$0	60% (after deductible)
Fertility Office Visits	80% (after deductible)	60% (after deductible)
Outpatient Mental Illness/Substance Use Disorder Physician Treatments	80% (after deductible) Notification required if it results in ***inpatient*** stay – otherwise $500 non-notification penalty will apply.	60% (after deductible) Notification required if it results in ***inpatient*** stay – otherwise $500 non-notification penalty will apply.
Virtual Visits (Behavioral or Mental Health diagnosis only)	80% (after deductible)	60% (after deductible)
Type of Service	**In-Network**	**Out-of-Network**
Coinsurance	**Plan Pays**	**Plan Pays****
Emergency Room	80% (after deductible) Notification required if it results in ***inpatient*** stay – otherwise $500 non-notification penalty will apply.	80% (after deductible) Notification required if it results in ***inpatient*** stay – otherwise $500 non-notification penalty will apply.
Inpatient Hospital Services	Notification required if it results in ***inpatient*** stay – otherwise $500 non-notification penalty will apply.	Notification required if it results in ***inpatient*** stay – otherwise $500 non-notification penalty will apply.
‣ ***Hospital***/Facility/Ancillary Services	80% (after deductible)	60% (after deductible)

Type of Service	In-Network	Out-of-Network
‣ Physicians Services	80% (after deductible)	60% (after deductible)
‣ Skilled Nursing Facility	80% (after deductible	60% (after deductible)
‣ Home Health Care	80% (after deductible)	60% (after deductible)
‣ Hospice Care	100% (after deductible)	100% (after deductible)
‣ Therapy (Physical, Occupational and Speech)	80% (after deductible)	60% (after deductible)
‣ Maternity Services	80% (after deductible)	60% (after deductible)
‣ Preadmission Testing	80% (after deductible)	60% (after deductible)
Outpatient Hospital Services		
‣ ***Hospital***/Facility Services	80% (after deductible)	60% (after deductible)
‣ ***Physician*** Services	80% (after deductible)	60% (after deductible)
‣ Outpatient Therapy	80% (after deductible)	60% (after deductible)
‣ Renal Dialysis Treatments	80% (after deductible)	60% (after deductible)
‣ ***Surgical*** Services	80% (after deductible)	60% (after deductible)
‣ Ambulatory Surgical Facility	80% (after deductible)	60% (after deductible)
‣ Outpatient Diagnostic Services	80% (after deductible)	60% (after deductible)
‣ Cardiac Rehabilitation	80% (after deductible)	60% (after deductible)
Professional Services		
‣ Office Visits	80% (after deductible)	60% (after deductible)
‣ Consultations or ***Medical Care*** Visits	80% (after deductible)	60% (after deductible)
‣ ***Surgical*** Services	80% (after deductible)	60% (after deductible)
‣ Second ***Surgical*** Opinions	80% (after deductible)	60% (after deductible)
‣ Outpatient Diagnostic Services	80% (after deductible)	60% (after deductible)
Coinsurance	**Plan Pays**	**Plan Pays****
‣ Therapy treatments (radiation, shock therapy and ***chemotherapy***)	80% (after deductible)	60% (after deductible)
‣ Outpatient Physical, Occupational and Speech Therapy	80% (after deductible)	60% (after deductible)
‣ Chiropractor Services	80% (after deductible)	60% (after deductible)
‣ Diabetes Management Services	80% (after deductible)	60% (after deductible)

Type of Service	In-Network	Out-of-Network
Outpatient Emergency Accident Care and Emergency Medical Care (treatment must be received within 72 hours of accident)		
‣ Hospital (outpatient)	80% (after deductible)	80% (after deductible)
‣ Physician	80% (after deductible)	80% (after deductible)
‣ Emergency Room	80% (after deductible)	80% (after deductible)
Wellness (hospital and professional services)		
‣ Wellness Care		
Routine Physical Exams	100%	60% (after deductible)
Immunizations	100%	60% (after deductible)
Routine Diagnostic Tests	100%	60% (after deductible)
Routine Mammograms	100%	60% (after deductible)
Routine Pap Smear Tests	100%	60% (after deductible)
Prostate Tests	100%	60% (after deductible)
Digital Rectal Exams	100%	60% (after deductible)
Colorectal Cancer Screening	100%	60% (after deductible)
‣ Well Child Care (to age 16)	100%	60% (after deductible)
Other Covered Services		
‣ Elective Abortion	80% (after deductible)	60% (after deductible)
‣ Acupuncture (includes office visit)	80% (after deductible)	60% (after deductible)
‣ Allergy Shots and Surveys	80% (after deductible)	60% (after deductible)
‣ Ambulance Services	80% (after deductible)	60% (after deductible)
Coinsurance	**Plan Pays**	**Plan Pays****
‣ Blood and Blood Components	80% (after deductible)	60% (after deductible)
‣ Durable Medical Equipment	80% (after deductible)	60% (after deductible)
‣ Foot Orthotics	80% (after deductible)	60% (after deductible)
‣ Human Organ Transplants (when performed in a BCBS-approved program) including:	80% (after deductible)	Not covered
Heart;		

Type of Service	In-Network	Out-of-Network
Lung; Heart/lung; Liver; and Pancreas or pancreas/kidney		
‣ Human Organ Transplants, including: Cornea; Kidney; Bone marrow; Heart valve; Muscular-skeletal; and Parathyroid	80% (after deductible)	60% (after deductible)
‣ Fertility Coverage	80% (after deductible)	60% (after deductible)
‣ Leg, Back, Arm and Neck Braces	80% (after deductible)	60% (after deductible)
‣ Mastectomies	80% (after deductible)	60% (after deductible)
‣ Naprapathic Services	80% (after deductible)	60% (after deductible)
‣ Optometric Services	80% (after deductible)	60% (after deductible)
‣ Oxygen and its Administration	80% (after deductible)	60% (after deductible)
‣ Private Duty Nursing Services	80% (after deductible)	60% (after deductible)
‣ Prosthetic Appliances	80% (after deductible)	60% (after deductible)
‣ Elective Sterilization		
Physician	80% (after deductible)	60% (after deductible)
Facility	80% (after deductible)	60% (after deductible)
Coinsurance	**Plan Pays**	**Plan Pays**[**]
‣ Temporomandibular Joint Dysfunction and Related Medical Disorders	80% (after deductible)	60% (after deductible)
‣ Medical Supplies, ***Surgical*** Dressings and Casts	80% (after deductible)	60% (after deductible)
Mental Illness/Substance Use Disorder Treatments		
‣ ***Inpatient*** Facility Services	80% (after deductible)	60% (after deductible)

Type of Service	In-Network	Out-of-Network
‣ Inpatient Physician Services	80% (after deductible)	60% (after deductible)
‣ ***Outpatient*** Facility Services	80% (after deductible)	60% (after deductible)
‣ Outpatient Physician Services	80% (after deductible)	60% (after deductible)
‣ Virtual Visits	80% (after deductible)	60% (after deductible)
Maximum Benefits†		
Lifetime Maximum (applicable to all covered in-network and out-of-network services)	Unlimited	Unlimited
Inpatient Skilled Nursing Facility	100 days per year	100 days per year
Home Health Care	100 visits per year	100 visits per year
Outpatient Cardiac Rehabilitation Services	36 treatment sessions within a six-month period	36 treatment sessions within a six-month period
Physical Therapy (outpatient)	30 visits per year	30 visits per year
Occupational Therapy (outpatient)	30 visits per year	30 visits per year
Speech Therapy (outpatient)	30 visits per year	30 visits per year
Chiropractor Services (outpatient)	30 visits per year	30 visits per year
Wellness Benefits	None	None
Acupuncture	30 visits per year	30 visits per year
Foot Orthotics	Four per year (hard or soft)	Four per year (hard or soft)
Human Organ Transplant Travel Companion Benefit	$10,000 per lifetime	Not covered
Fertility Coverage[1]	$15,000 per lifetime for artificial reproduction technology (ART) which includes artificial insemination, IVF, ZIFT and GIFT.	$15,000 per lifetime for artificial reproduction technology (ART) which includes artificial insemination, IVF, ZIFT and GIFT.
• Autism Spectrum Disorders	Unlimited	Unlimited
• Speech Therapy for Pervasive Developmental Disorders	20 visits per year	20 visits per year

Type of Service	In-Network	Out-of-Network
Maximum Benefits†		
Naprapathic Services	30 visits per year	30 visits per year
Private Duty Nursing Services	15 visits per month	15 visits per month
Temporomandibular Joint Dysfunction and Related Medical Disorders	$2,500 per lifetime	$2,500 per lifetime

* The entire family deductible must be met before the Plan pays benefits. Once an individual's out of pocket is met, eligible services are paid at 100%

** If you receive care outside the network, the Plan pays benefits based on the ***maximum allowance*** for the service. If you receive care from a ***non-administrator provider***, benefits will be provided at 50% of the ***eligible charge***.

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

† Maximum benefits shown are combined maximums for in-network and out-of-network services.

[1] *Cryopreservation and Storage service will still be required to follow medical policy language; currently services are not covered per medical policy.*

About Your Coverage Options

The chart below gives a brief description of how the PPO works.

Blue Cross Blue Shield PPO

- You have access to a network of ***participating providers.*** Visit www.bcbsil.com for up-to-date listings. These ***physicians***, ***hospitals*** and treatment facilities agree to charge lower ***negotiated rates***.
- At the point that you require care, you decide whether to see a ***participating*** or ***non-participating provider***. (See Glossary for details).
- If you see a ***participating provider***, the Plan pays a higher percentage of your ***eligible expenses***.

  If you receive in-network care, you may need to meet a ***copayment*** or deductible requirement before the Plan pays benefits for certain services. See the snapshot chart beginning on page 24 for the services that require a ***copayment*** or deductible.

  The chart also includes the percentage the Plan pays for each ***covered service***. Your share of ***covered services*** is called your ***coinsurance*** (see Glossary for details).
- If you go outside the network, you are responsible for a greater percentage of the ***eligible expense*** after you meet the annual deductible requirement. In addition, you may also have to pay the difference between the ***provider***'s charge and the ***maximum allowance***.
- You can select a ***participating provider*** from a directory of ***participating providers***. For a complete list of ***participating providers*** visit www.bcbsil.com/providers or you can call Blue Cross Blue Shield at 1-800-810-2583 for a copy.
- If you select the PPO option, your coverage includes prescription drug coverage. See the prescription drug plan section of this SPD for details.

For certain ***inpatient*** services, you need to contact the Medical Services Advisory (MSA) Program and comply with its determinations. If you do not, the Plan reduces benefits. See the Medical Services Advisory (MSA) Program section of this document for more information.

While the directory of ***participating providers*** under the PPO may change from time to time, the ***Claim Administrator*** continues to select ***participating providers*** based on their range of services, geographic location, and cost-effectiveness of care. For an up to date listing of ***providers*** visit www.bcbsil.com/providers or call Blue Cross Blue Shield at 1-800-810-2583. You can also

check with your ***provider*** before you undergo treatment to make sure that he or she is still participating.

If you live outside the PPO network service area – or, more than 30 miles away from a ***PPO provider***, please call Medical Services Advisory (MSA) for a waiver of services. This entitles you to the in-network level of benefits, even if you receive care from a ***non-participating provider***. Please refer to your ID Card for the MSA's toll-free number. Also, please refer to the Medical Services Advisory (MSA) Program section of this document for more information.

BlueCard Worldwide Program

If you are outside the United States, the Commonwealth of Puerto Rico, and the U.S. Virgin Islands (hereinafter "BlueCard service area"), you may be able to take advantage of the BlueCard Worldwide Program when accessing Covered Services. The BlueCard Worldwide Program is unlike the BlueCard Program available in the BlueCard service area in certain ways. For instance, although the BlueCard Worldwide Program assists you with accessing a network of Inpatient, Outpatient and professional Providers, the network is not served by a Host Blue. As such when you receive care from Providers outside the BlueCard service area, you will typically have to pay the Providers and submit the Claims yourself to obtain reimbursement for these services.

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

Inpatient Services

In most cases, if you contact the BlueCard Worldwide Service Center for assistance, Hospitals will not require you to pay for covered Inpatient services, except for your cost share amounts/deductibles, Coinsurance, etc. In such cases, the Hospital will submit your Claims to the BlueCard Worldwide Service Center to begin Claims processing. However, if you paid in full at the time of service, you must submit a claim to receive reimbursement for Covered Services. You must contact the Plan to obtain Preauthorization for non-emergency inpatient services.

Outpatient Services

Outpatient Services are available for Emergency Care, Physicians, urgent care centers and other Outpatient Providers located outside the BlueCard service area will typically require you to pay in full at the time of service. You must submit a claim to obtain reimbursement for Covered Services.

Submitting a BlueCard Worldwide Claim

When you pay for Covered Services outside the BlueCard service area, you must submit a claim to obtain reimbursement. For institutional and professional Claims, you should complete a BlueCard Worldwide International claim form with the Provider's itemized bill(s) to the BlueCard Worldwide Service Center (the address is on the form) to initiate Claims processing. Following the instructions on the claim form will help ensure timely processing of your claim. The claim form is available from the Plan, the BlueCard Worldwide Service Center or online at www.bluecardworldwide. com. If you need assistance with your claim submission, you should call the BlueCard Worldwide Service Center at 1-800-810-BLUE (2583) or call collect at 1-804-673-1177, 24 hours a day, seven days a week.

Choosing Whom to Cover

In addition to selecting a coverage option, you need to decide whom to cover by selecting a coverage level. You can select from the following coverage levels:

- Employee Only;
- Employee Plus Spouse
- Employee Plus Child(ren)
- Employee Plus Family

How Benefits Are Paid

Depending on whether you receive in-network or out-of-network ***medical care***, an annual deductible, ***copayment***, ***coinsurance*** or annual out-of-pocket maximum may apply.

Here's a brief description of each feature.

Deductible

The deductible is the fixed dollar amount that you pay out of your pocket each year before you receive benefits. See the snapshot charts to determine the deductible amount that applies.

The individual deductible applies separately to each covered individual. The family deductible applies collectively to all covered persons in the same family. Once you meet the family deductible maximum, the Plan begins to pay benefits.

Copayments

A ***copayment*** is a fixed-dollar amount that you may pay for certain services before the Plan pays benefits. See the snapshot chart for the services that require a ***copayment*** before the Plan pays benefits.

Copayments generally apply to office-type visits and prescription drug services. ***Copayments*** do not apply toward any deductible or ***coinsurance*** requirement you may have. Office visit ***copayments*** will apply to the annual out-of-pocket maximum.

Coinsurance

This is the percentage of ***eligible expenses*** you are responsible for paying. ***Coinsurance*** percentages apply after any applicable deductibles. The ***coinsurance*** amount you pay depends on the type of service you receive. See the snapshot charts for the ***coinsurance*** percentage paid for each type of ***eligible expense*** under your coverage option.

Please note: If you receive care from a ***non-participating provider***, the percentage paid applies only to ***eligible expenses*** that do not exceed the ***maximum allowance.*** You are responsible for any non-***covered service***, including any amounts that exceed the ***maximum allowance*** and the applicable ***coinsurance*** percentage.

Annual Out-of-Pocket Maximums

The out-of-pocket maximum is the most you have to pay in deductible, ***coinsurance*** and office visit ***copayments*** for ***eligible expenses*** in one ***plan year***. See the snapshot chart for the individual and family out-of-pocket maximums that apply to your coverage.

Once you reach your individual out-of-pocket maximum, the Plan pays 100% of your additional ***eligible expenses*** for the remainder of that ***plan year***. The family out-of-pocket maximum

applies collectively to all covered family members. Once you meet the family out-of-pocket maximum, the Plan pays 100% of ***eligible expenses*** for any covered family member for the remainder of that year. So, if your ***family coverage*** includes yourself and one dependent, you and your dependent need to satisfy one family out-of-pocket maximum. However, a single-family member cannot apply more than the individual out-of-pocket limit toward this amount.

Certain charges do not apply toward the out-of-pocket maximum. These include:

Any additional expense you may be required to pay for not following the Medical Services Advisory (MSA) Program (where applicable);

Coinsurance dollars from facilities of a non-administrator provider.

Any expense that's not considered an eligible expense that is above the maximum allowance, or that exceeds other Plan limits.

Benefit Maximums

The individual lifetime maximum is the maximum amount that the Plan pays for ***eligible expenses*** during the life of a covered individual. The Plan generally provides an unlimited amount of benefits per lifetime for both in-network and out-of-network ***eligible expenses***. See the snapshot chart for details.

However, the Plan does limit benefits for certain ***eligible expenses***. See the snapshot chart for details regarding the maximums that apply to certain services.

Please Note: All benefits payable under the Plan are cumulative. This means that when the Plan calculates the benefit maximums for a particular service or ***eligible expense***, it includes benefit payments under both this and any prior health care program administered by the ***Claim Administrator***.

Travel Benefits

You will be reimbursed for travel expenses for transportation and lodging that you incur for travel that is necessary to obtain any Covered Service rendered by a Participating Provider if there is no Participating Provider able to perform that service located within 100 miles of your home address (such benefits referred to herein as "Travel Benefits"). Coverage is available for you and up to one companion, or, if the person receiving the Covered Service is under age 18, up to two companions. Reimbursement for lodging is limited to $50 per night for you and an additional $50 per night for each permitted companion. To obtain reimbursement, you will need to submit a form, which includes receipts and supporting documentation of your expenses. Meals are not reimbursable. Travel Benefits are limited to a cap of $2,000 annually. Reimbursement is subject to the service, travel, and reimbursement being in accordance with all applicable laws or regulations.

Extension of Benefits (If Terminated)

If you are receiving ***inpatient*** care when your coverage ends, the Plan pays benefits for ***eligible expenses*** charged by the following facilities or programs until you are discharged, you reach the applicable benefit limit (if any), or until the end of the ***plan year*** (whichever occurs first):

- Hospital;
- Skilled nursing facility;
- Substance use disorder treatment facility;
- Partial hospitalization treatment program; or
- Coordinated home care program.

Blue Cross Blue Shield Network

The ***Company*** offers national PPO coverage through Blue Cross Blue Shield, one of the largest group health care networks in the country. The PPO is designed to provide you economic incentives for using designated ***providers*** for health care services.

As a PPO participant, you have access to a network of ***participating providers*** that agree to charge lower, ***negotiated rates*** for care. As a PPO participant, even though you can choose to receive in-network or out-of-network services, the Plan pays a higher level of benefit when you receive care from ***participating providers***.

A ***provider*** who participates in the network has a written agreement with the ***Claim Administrator*** (or another Blue Cross and Blue Shield Plan or Blue Cross Plan).

You can select a ***participating provider*** from a directory of ***participating providers***. For a complete list of ***participating providers*** visit www.bcbsil.com/providers or you can call Blue Cross Blue Shield at 1-800-810-2583 for a copy.

Your ID Card

If you elect coverage for yourself, you receive one identification card in your name. If you elect ***family coverage***, you receive an additional ID card in your name. You receive ID cards shortly after you enroll. The card tells you your identification number. Because some ***providers*** require that you show your ID card prior to treatment, your card is very important to obtain benefits.

Covered Services

The Plan pays benefits – up to the ***maximum allowance*** – for ***medically necessary eligible expenses***. The snapshot chart provides details as to how the Plan pays benefits for each ***eligible expense***. It also includes any benefit limits, ***copayments*** or deductible requirements that may apply. This section of the SPD details the services covered under the Plan.

Please note that not all of the terms of coverage can be covered in this plan document. The ***Claim Administrator's*** protocols will provide rules both for coverage of services for particular conditions and determinations of whether a service is ***medically necessary***. A service will not be treated as ***medically necessary*** merely because it is prescribed by a licensed ***physician*** or other medical ***provider***. This Plan is intended to provide payment for certain services and does not assure that payment for all forms or courses of treatment, even if a bona fide medical condition is found to exist.

Be sure to reference the Glossary of Terms and the Medical Expenses Not Covered sections for various limits and/or special conditions that pertain to your Plan benefits. Also, please see the Medical Services Advisory (MSA) Program section for details regarding when you need to contact the MSA Program to avoid a reduction of benefits.

Inpatient Hospital Services

The Plan pays benefits for the following ***inpatient hospital*** medical services and supplies.

Hospital facility services – such as room and board – when you are in:

- A semi-private room;
- A private room (the Plan limits benefits to the *hospital's* rate for the most common type of room with two or more beds); or
- An intensive care unit.

Hospital ancillary services and supplies, including:

- Operating room charges;
- Drugs;
- *Surgical* dressings; and
- Laboratory work.

Physicians' services while you are hospitalized.

General nursing care when you are in:

- A semi-private room;
- A private room; or
- An intensive care unit.

Skilled nursing or extended care facility charges, including:

- Bed, board and general nursing care; and
- Ancillary services (such as drugs, *surgical* dressings or supplies).

- The Plan pays benefits for up to 100 days of care per year in a *skilled nursing facility*. It does not pay benefits for services received in an uncertified *skilled nursing facility*.

Home health care services provided under a coordinated home care program. The Plan pays benefits for up to 100 visits per year.

Hospice care services provided through an accredited hospice care program, including:

- Coordinated home care program;
- Medical supplies and dressings;
- Medications;
- Nursing services (skilled and non-skilled);
- Occupational therapy;
- Pain management services;
- Physical therapy; and
- Physician visits.

To be eligible for ***hospice care*** benefits, you must be terminally ill and your attending ***physician*** must certify that your life expectancy is one year or less. Your ***physician*** must also indicate that you'll no longer benefit from standard ***medical care***, or that you have elected to receive ***hospice care*** rather than standard care. In addition, a family member or friend must be available to provide custodial-type care between ***hospice care*** visits if you are receiving ***hospice care*** at home.

The Plan does not pay ***hospice care*** benefits for:

- Durable medical equipment;
- Home-delivered meals;
- Homemaker services;
- Respite care service;
- Traditional medical services provided for the direct care of the terminal illness, disease or condition;
- Transportation, including, but not limited to, ambulance transportation; or
- Care provided by a family member or friend.

There may be instances when short episodes of traditional care are appropriate – even if you remain in the hospice setting. Even if the traditional services are not eligible for ***hospice care*** benefits, the Plan may still cover them.

Therapy provided while you are in the hospital, including:

- Physical therapy;
- Occupational therapy; and
- *Speech therapy* (provided the *speech therapy* is not the only reason for the *hospital* admission).

Maternity services – Your benefits for maternity services are the same as your benefits for any other condition and are available whether you have individual coverage or family coverage. Benefits will also be provided for covered services rendered by a certified nurse-midwife. Benefits will be paid for covered services received in connection with both normal pregnancy and complications of pregnancy. As part of your maternity benefits certain services rendered to your newborn infant are also covered, even if you have individual coverage. These covered services are: (a) the routine inpatient hospital nursery charges and (b) one routine inpatient examination and (c) one inpatient hearing screening as long as this examination is rendered by a physician other than the physician who delivered the child or administered anesthesia during delivery. (If the newborn child needs treatment for an illness or injury, benefits will be available for that care only if you have family coverage. You may apply for family coverage within 31 days of the date of the birth. Your family coverage will then be effective from the date of the birth.) Benefits will be provided for any hospital length of stay in connection with childbirth for the mother or newborn child for no less than 48 hours following a normal vaginal delivery, or no less than 96 hours following a cesarean section. Generally, nothing prohibits the attending provider or physician, after consulting with the You (the mother), from discharging You (the mother) or Your (her) newborn earlier than 48 hours (or 96 hours, as applicable).Your provider will not be required to obtain authorization from the Claim Administrator for prescribing a length of stay less than 48 hours (or 96 hours). Your coverage also includes benefits for elective abortions if legal where performed.

Preadmission testing for preoperative tests performed before inpatient surgery. These tests are considered part of your inpatient hospital surgical stay, and are performed on an outpatient basis. The Plan pays benefits provided you would have otherwise been eligible to receive such tests as a hospital inpatient. The Plan does not pay benefits for preadmission testing if you decide to postpone your surgery.

When you receive inpatient covered services from a non-administrator provider, benefits will be provided at 50% of the eligible expense after you have met your program deductible and your inpatient hospital admission deductible.

Benefits for an inpatient hospital admission to a non-administrator or non-participating provider resulting from emergency accident care or emergency medical care will be provided at the same payment level which you would have received had you been in a participating hospital for that portion of your inpatient hospital stay during which your condition is reasonably determined by the Claim Administrator to be serious and therefore not permitting your safe transfer to a participating hospital or other participating provider.

Benefits for an inpatient hospital admission to a non-administrator or non-participating hospital resulting from emergency accident care or emergency medical care will be provided at the non-participating hospital payment level or the non-administrator hospital payment level (depending on the type of provider) for that portion of your inpatient hospital stay during which your condition is reasonably determined by the Claim Administrator as not being serious and therefore permitting your safe transfer to a participating hospital or other participating provider.

In order for you to continue to receive benefits at the participating provider payment level following an emergency admission to a non-administrator or non-participating hospital, you must transfer to a participating provider as soon as your condition is no longer serious.

Outpatient Hospital Services

The Plan pays benefits for the following ***hospital*** services, provided you receive them on an ***outpatient*** basis.

Hospital facility services and ancillary charges for services performed on an outpatient basis.

Outpatient therapy treatments, including:

- Radiation therapy;
- Chemotherapy; and
- Shock therapy.

Renal dialysis treatments if received in:

- A hospital;
- A dialysis facility; or
- Your home under the supervision of a *hospital* or *dialysis facility*.

Surgery services and any related diagnostic services received on the same day as the outpatient surgery.

Surgery services performed in an ambulatory surgical facility.

Diagnostic services, provided you are an outpatient and the services are related to the surgery or medical care.

Cardiac rehabilitation services performed on an outpatient basis. The Plan pays benefits provided the Claim Administrator approves your rehabilitation program and you receive services within six months after your inpatient stay for either:

- Myocardial infarction;
- Coronary artery bypass graft *surgery*; or
- Precutaneous transluminal coronary angioplasty
- Heart valve *surgery*,
- Heart transplantation
- Stable angina pectoris,
- Compensated heart failure; or
- Transmyocardial revascularization.

The Plan limits benefits to 36 ***outpatient*** treatment sessions within the six-month period.

Emergency Accident Care – treatment must occur within 72 hours of the accident or as soon as reasonably possible.

Emergency Medical Care

Mammograms – Benefits for routine mammograms will be provided at the benefit payment level described in the wellness care provisions of this SPD. Benefits for mammograms, other than routine, will be provided at the same payment level as outpatient diagnostic services.

Pap Smear Test – Benefits will be provided for an annual routine cervical smear or Pap smear test for females at the benefit payment level described in the wellness care provisions of this SPD.

Prostate Test and Digital Rectal Examination – Benefits will be provided for an annual routine prostate-specific antigen test and digital rectal examination for males at the benefit payment level described in the wellness care provisions of this SPD.

Ovarian Cancer Screening – Benefits will be provided for annual ovarian cancer screening for females using CA-125 serum tumor market testing, transvaginal ultrasound, and pelvic examination. Benefits will be provided at the benefit payment level described in the wellness care provisions of this SPD.

Colorectal Cancer Screening – Benefits will be provided for colorectal cancer screening as prescribed by a physician, in accordance with the published American Cancer Society guidelines on colorectal cancer screening or other existing colorectal cancer screening guidelines issued by nationally recognized professional medical societies or federal government agencies, including the National Cancer Institute, the Centers for Disease Control and Prevention, and the American College of Gastroenterology. Benefits for colorectal cancer screening will be provided at the benefit payment level described in the wellness care provisions of this SPD.

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

Benefit Payment for Outpatient Hospital Covered Services

Participating Provider. Benefits will be provided at 80% of the eligible charge under the Standard PPO and Premier PPO plan when you receive outpatient hospital covered services from a participating provider.

Non-Administrator Provider. When you receive outpatient hospital covered services from a non-administrator provider, benefits will be provided at 50% of the eligible charge. Covered services received for emergency accident care and emergency medical care from a non-administrator provider will be paid at the same payment level which would have been paid had such services been received from a participating provider.

Emergency Care. Benefits for emergency accident care will be provided at 80% of the eligible charge under the Standard PPO and Premier PPO plan when you receive covered services from either a participating, non-participating or non-administrator provider. Benefits for surgical procedures, such as stitching, gluing and casting are not provided at the emergency accident care payment level. Such services will be provided at the benefit payment level for surgery described in this SPD. 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.

Notwithstanding anything in this SPD to the contrary, the method used to determine the maximum allowance for emergency accident care and emergency medical care services will be equal to the greatest of the following three possible amounts:

- the amount negotiated with ***participating providers*** for ***emergency accident care*** and ***emergency medical care*** benefits furnished; or
- the amount for the ***emergency accident care*** and ***emergency medical care*** service calculated using the same method the ***participating providers*** generally uses to determine pay-ments for ***non-participating provider*** services but substituting the ***participating provider*** cost sharing provisions for the ***non-participating provider*** cost-sharing provisions; or
- the amount that would be paid under ***Medicare*** for the emergency are service.

Each of these three amounts is calculated excluding any non-participating provider copayment or coinsurance imposed with respect to the covered person.

When Services are not Available from a Participating Provider (Hospital)

If you must receive ***hospital covered services*** which the ***Claim Administrator*** has reasonably determined are unavailable from a ***participating provider***, benefits for the ***covered services*** you receive from a ***non-participating provider*** will be provided at the payment level described for a ***participating provider***.

Professional Services

The Plan pays benefits for care you receive from a ***physician*** or other specified professional ***provider***. How much the Plan pays depends on whether you receive care from a ***participating***, or ***non-participating***.

Office visits. You must meet the copayment requirement before the Plan pays benefits. See the snapshot chart for the copayment amount that applies to these services.

Consultations while you are hospitalized or while you are an inpatient in a skilled nursing facility. Your attending physician must request the consultation because the diagnosis or treatment of your condition requires the advice and special skill or knowledge of another physician. The Plan does not pay benefits for any consultation that's done because of hospital regulations, nor does it pay benefits for any consultation performed by a physician who renders the surgery or maternity service during the same admission.

Medical care visits received:

- While you are an inpatient in a hospital or skilled nursing facility;
- While you are a patient in a *coordinated home care program*;
- On an *outpatient* basis; or
- In a *physician*'s office or at your home.

Surgical services performed by a physician, dentist or podiatrist, including:

- Sterilization procedures (if they're *medically necessary* or elective);
- *Anesthesia services*, if administered at the same time as a covered *surgical* procedure in a *hospital* or *ambulatory surgical facility*, or by a *physician* other than the operating surgeon or by a *CRNA*; 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) a child is age 6 and under, (b) you have a chronic disability, or (c) you have a medical condition requiring hospitalization or general anesthesia for dental care.
- Services performed by an *assistant surgeon* (the Plan pays benefits only if a *hospital* intern or resident is not available for such assistance).
- *Surgery* for removal of complete bony impacted teeth;
- Excision of tumors or cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth;

- *Surgery* procedures to correct accidental medical injuries of the jaws, cheeks, lips, tongue, roof and floor of the mouth;
- Excision of exostoses of the jaws and hard palate (provided this procedure is not done to prepare for dentures or other prostheses);
- The treatment of facial bone fractures;
- External incision and drainage of cellulites;
- Incision of accessory sinuses, salivary glands or ducts; and
- Reduction of dislocation of, or excision of, the temporomandibular joints.

If a dentist or podiatrist performs surgery services, the Plan limits benefits to those surgery procedures that may be legally rendered by them and that would be payable under the Plan had they been performed by a physician.

A second surgical opinion after your provider recommends elective surgery. The Plan limits benefits to one consultation and related diagnostic service by a physician. The Plan pays 100% for any additional surgical opinion consultation and related diagnostic service. If you feel additional consultations are needed, the Plan pays additional benefits at the 100% level.

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.

Outpatient diagnostic services related to a covered surgery or medical care, including:

- X-rays; and
- Laboratory exams.

Therapy treatments, including:

- Radiation therapy treatments;
- Shock therapy treatments; and
- Chemotherapy.

Occupational Therapy – Benefits will be provided for occupational therapy when these services are rendered by a registered occupational therapist under the supervision of a physician. This therapy must be furnished under a written plan established by a physician and regularly reviewed by the therapist and physician. The plan must be established before treatment is begun and must relate to the type, amount, frequency and duration of therapy and indicate the diagnosis and anticipated goals. Benefits for outpatient occupational therapy will be limited to a maximum of 30 visits per year.

Physical Therapy – Benefits will be provided for physical therapy when rendered by a registered professional physical therapist under the supervision of a physician. The therapy must be furnished under a written plan established by a physician and regularly reviewed by the therapist and the physician. The plan must be established before treatment is begun and must relate to the type, amount, frequency and duration of therapy and indicate the diagnosis and anticipated goals. Benefits for outpatient physical therapy will be limited to a maximum of 30 visits per year.

Chiropractor Services and Osteopathic Manipulation – Benefits will be provided for chiropractor services including 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. Benefits for chiropractor services and osteopathic manipulation will be limited to a maximum of 30 visits per year.

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. Outpatient speech therapy benefits will be limited to a maximum of 30 visits per year. However, benefits will be provided for an additional 20 visits for speech therapy for treatment of pervasive developmental disorders.

Mammograms – Benefits for routine mammograms will be provided at the benefit payment level described in the wellness care provisions of this SPD. Benefits for mammograms, other than routine, will be provided at the same payment level as outpatient diagnostic services.

Pap Smear Test – Benefits will be provided for an annual routine cervical smear or Pap smear test for females at the benefit payment level described in the wellness care provisions of this SPD.

Prostate Test and Digital Rectal Examination – Benefits will be provided for an annual routine prostate-specific antigen test and digital rectal examination for males at the benefit payment level described in the wellness care provisions of this SPD.

Ovarian Cancer Screening – Benefits will be provided for annual ovarian cancer screening for females using CA-125 serum tumor marker testing, transvaginal ultrasound, and pelvic examination. Benefits for ovarian cancer screening will be provided at the benefit payment level described in the wellness care provisions of this SPD.

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

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

Diabetes Self-Management Training and Education – Benefits will be provided for outpatient self-management training, education and medical nutrition therapy. Benefits will be provided if these services are rendered by a physician, or duly certified, registered or licensed health care professionals with expertise in diabetes management. Benefits for such health care professionals will be provided at the Benefit Payment for Other covered services described in the Other Covered Services section of this SPD. Benefits for physicians will be provided at the Benefit Payment for physician Services described later in this benefit section. Benefits are also available for regular foot care examinations by a physician or podiatrist.

Clinical Breast Examination – 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. Benefits for clinical breast examinations will be provided at the benefit payment level described in the wellness care provisions of this SPD.

Human Papillomavirus Vaccine – Benefits will be provided for a human papillomavirus (HPV) vaccine approved by the federal Food and Drug Administration. Benefits will be provided at the benefit payment level for immunizations described in the wellness care provisions of this SPD. If you purchase the vaccine at a pharmacy, benefits will be provided at the Benefit Payment for Other Covered Services described in the Other Covered Services section of this SPD.

Outpatient Contraceptive Services – Benefits will be provided for prescription contraceptive devices, injections, implants and outpatient contraceptive services. Outpatient contraceptive services means consultations, examinations, procedures and medical services provided on an outpatient basis and related to the use of contraceptive methods (including natural family planning) to prevent an unintended pregnancy.

Leg, Back, Arm and Neck Braces Prosthetic Appliances – Benefits will be provided for prosthetic devices, special appliances and surgical implants when:

- they are required to replace all or part of an organ or tissue of the human body, or
- they are required to replace all or part of the function of a non-functioning or malfunctioning organ tissue

Benefits will also include adjustments, repair and replacements of covered prosthetic devices, special appliances and ***surgical*** implants when required because of wear or change in a patient's condition (excluding dental appliances other than intra-oral devices used in connection with the treatment of ***temporomandibular joint dysfunction and related disorders***, subject to specific limitations applicable to ***temporomandibular joint dysfunction and related disorders***, and replacement of cataract lenses when a prescription change is not required).

- **Orthotic Devices** - Benefits will be provided for a supportive device for the body or a part of the body, head, neck or extremities, including but not limited to, leg, back, arm and neck braces. In addition, benefits will be provided for adjustments, repairs or replacement of the device because of a change in your physical condition, as ***medically necessary***. However, benefits will not be provided for foot orthotics defined as any in-shoe device designed to support the structural components of the foot during weight-bearing activities.

- **Amino Acid-Based Elemental Formulas**—Benefits will be provided for amino acid-based elemental formulas for the diagnosis and treatment of eosinophilic disorders or short-bowel syndrome, when the prescribing ***physician*** has issued a written order stating that the amino acid-based elemental formula is ***medically necessary***. If you purchase the formula at a ***pharmacy***, benefits will be provided at the Benefit Payment for Other Covered Services described in the Other Covered Services section of this SPD.

Shingles Vaccine – Benefits will be provided for a shingles vaccine approved by the Federal Food and Drug Administration at the benefit payment level described in the wellness care provisions of this SPD.

Colorectal Cancer Screening – Benefits will be provided for colorectal cancer screening as prescribed by a physician, in accordance with the published American Cancer Society guidelines on colorectal cancer screening or other existing colorectal cancer screening guidelines issued by nationally recognized professional medical societies or federal government

agencies, including the National Cancer Institute, the Centers for Disease Control and Prevention, and the American College of Gastroenterology. Benefits for colorectal cancer screening will be provided at the benefit payment level described in the wellness care provisions of this SPD. Benefits for surgical procedures, such as colonoscopy and sigmoidoscopy are provided at the wellness care payment level.

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

Approved Clinical Trials—Benefits for Covered Services for Routine Patient Costs are provided in connection with a phase I, phase II, phase III or phase IV clinical trial that is conducted in relation to the prevention, detection or treatment of cancer or other Life-Threatening Disease or Condition and is recognized under state and/or federal law.

Outpatient Emergency Accident and Medical Care Services

The Plan pays benefits for ***emergency accident care*** and ***emergency medical care***. If your condition is life threatening and you receive emergency care at a ***hospital*** outside the network because it's not possible to safely transfer you to a ***hospital*** within the network, the plan pays benefits at the in-network level. The Plan only continues paying benefits at the in-network level if you transfer to an in-network ***hospital*** as soon as your condition is no longer life threatening. If the ***Claim Administrator*** determines that your condition is not life threatening and you still receive out-of-network care, the Plan pays benefits at the out-of-network level.

Emergency accident care and initial treatment of an accidental medical injury, including:

- *Hospital* services;
- *Physician* services; and
- Emergency room care (if you are admitted, your emergency room *copayment* applies to your deductible requirement).

To be eligible for benefits, the initial treatment must be received within 72 hours of the accident. However, the Plan pays 100% of ***eligible expenses*** with no deductible requirement if you require treatment because of a criminal sexual assault or abuse. In addition, the emergency room ***copayment*** requirement does not apply.

Emergency medical care for the initial treatment of a medical emergency, including:

- *Hospital* services;
- *Physician* services; and
- Emergency room care (if you are admitted, your emergency room *copayment* applies to your deductible requirement).

The Plan pays 100% of ***eligible expenses*** with no deductible requirement if you require treatment because of a criminal sexual assault or abuse. In addition, the emergency room ***copayment*** requirement does not apply.

Preventive Care Services

Benefits will be provided for preventive care services as described below and will not be subject to any deductible, Coinsurance, Copayment or dollar maximum when such services are received from a Participating Provider:

a. 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");
b. immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention ("CDC") with respect to the individual involved;
c. evidenced-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration ("HRSA") for infants, child(ren), and adolescents; and
d. with respect to women, such additional preventive care and screenings, not described in item "a" above, as provided for in comprehensive guidelines supported by the HRSA.

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 in items a through d above may change as USPSTF, CDC and HRSA guidelines are modified. For more information, you may access the Blue Cross and Blue Shield Web site at www.bcbsil.com or contact customer service at the toll-free number on your identification card.

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

Examples of covered immunizations included are: Diphtheria, Haemophilus influenzae type b, Hepatitis B, Measles, Mumps, Pertussis, Polio, Rubella, Tetanus, Varicella and any other immunizations that is required by law for a child. Allergy injections are not considered immunizations under this benefit provision.

Preventive services received from a ***non-participating provider*** or other routine ***covered services*** not provided for under this provision will be subject to the deductible, ***coinsurance***, ***copayments*** and/or benefit maximum as described under the Well Child Care and/or ***wellness care*** provisions of this SPD.

Wellness (Hospital and Professional Services)

The Plan pays benefits for ***wellness care*** and well child care services, including:

- Routine physical exams;
- Immunizations;
- Routine diagnostic tests;
- Hospital services;
- Professional services;
- Routine mammograms;
- Routine annual cervical smear or pap test;

- Routine annual prostate-specific antigen test and digital rectal examination;
- Routine colorectal cancer screening with sigmoidoscopy or fecal occult blood tests;
- Routine colonoscopies;
- Routine sigmoidoscopies;
- Ovarian Cancer Screening; and
- Bone Mass Measurement and Osteoporosis

Other Covered Services

The Plan pays benefits for a variety of other medically necessary services. See the snapshot chart for the percentage the Plan pays for each eligible expense.

Elective abortions (if legal where performed by a physician).

Acupuncture treatments (inpatient or outpatient), including those performed in a physician's office. The Plan only pays benefits if a physician provides services. The Plan does not pay benefits if acupuncture is provided in lieu of anesthesia.

The Plan limits benefits for acupuncture treatments to 30 visits per year (this is a combined maximum and it applies to both in-network and out-of-network services).

Professional services associated with allergy shots and allergy surveys.

Ambulance services (local ground or air transportation to the nearest appropriately equipped facility). However, the Plan does not pay benefits for long-distance trips, or when ambulance services are more convenient than other types of transportation.

The processing, transporting, storing, handling and administration of blood and blood components.

Medical accident care, provided a dentist or physician renders the services and the services are required because of an accidental medical injury.

Durable medical equipment, including:

- Internal cardiac valves;
- Internal pacemakers;
- Mandibular reconstruction devices (not primarily used to support medical prosthesis);
- Bone screws, bolts, nails, plates and any other internal and permanent devices that are reasonably approved by the *Claim Administrator;*
- The rental or purchase of durable medical equipment that's primarily and customarily used to serve a medical purpose and is required for temporary therapeutic use (benefits are limited to the total cost of the equipment).

Orthopedic shoes and shoe inserts – Benefits will be provided for orthopedic shoes or shoe inserts when prescribed by a ***physician***. The plan limits benefits to a total of four hard or soft orthotics per year.

Gender Reassignment Surgery

Benefits will be provided for gender reassignment surgery for persons age 18 and over with **gender dysphoria**,

Gender dysphoria (formerly known as 'gender identity disorder') is a condition recognized by the Diagnostic and Statistical Manual (DSM) of Mental Disorders and commonly known as transsexualism. The diagnostic criteria describe many individuals who experience dissonance between their sex at birth and personal gender identity, which is not the same as having ambiguous genitalia.

Gender reassignment surgery -- also known as transsexual surgery or sex reassignment surgery -- and related services **may be considered medically necessary when meeting the criteria for gender dysphoria listed below.** Otherwise, gender reassignment surgery and related services will be considered not medically necessary.

Benefits for gender reassignment surgery will be unlimited. Benefits for gender reassignment surgery are the same as benefits for any other condition. Benefits will be provided for Covered services rendered to persons age 18 and over.

Criteria for Coverage of Gender Reassignment Surgery and Related Services:
The individual being considered for surgery and related services must meet **ALL** the following criteria. The individual **must have**:

- Reached the age of majority- at least 18 years of age **AND**
- The capacity to make a fully informed decision and to consent for treatment; **AND**
- Been diagnosed with persistent, well-documented **gender dysphoria, AND**
- Undergone a minimum of 12 months of continuous hormonal therapy when recommended by a mental health professional and provided under the supervision of a physician.
- Completed a minimum of 12 months of successful continuous full time real−life experience in their new gender, with no returning to their original gender.
- A letter from the individual's physician or mental health provider documenting treatments and medical necessity.
- Has the required referrals prior to any surgery or related service(s):
    - **Prior to feminizing or masculinizing hormonal therapy**, one required referral from the individual's qualified mental health professionals competent in the assessment and treatment of gender dysphoria; **and/or**
    - **Prior to breast/chest surgery**, e.g., mastectomy, chest reconstruction, or breast augmentation, one required referral from the individual's qualified mental health professionals competent in the assessment and treatment of gender dysphoria; **and/or**
    - **Prior to any genital surgery**, e.g., hysterectomy, salpingooophorectomy, orchiectomy, and/or other genital reconstructive procedures, two separate required independent referrals (or one signed by both referring providers) from the individual's qualified mental health professionals competent in the assessment, treatment of gender dysphoria, and addressing the identical/same surgery to be performed.

Gender Reassignment Surgeries and Related Services:

Procedures or services to create and maintain gender specific characteristics (masculinization or feminization) as part of the overall desired gender reassignment services treatment plan **may be considered medically necessary for the treatment of gender dysphoria ONLY.**

These procedures may include the following:
• Abdominoplasty;
• Blepharoplasty;
• Brow lift;
• Calf implants;
• Cheek implants;
• Chin or nose implants;
• External penile prosthesis (vacuum erection devices);
• Face lift (rhytidectomy);
• Facial bone reconstruction/sculpturing/reduction, includes jaw shortening;
• Forehead lift or contouring;
• Hair removal (may include donor skin sites) or hair transplantation (electrolysis or hairplasty);
• Laryngoplasty;
• Lip reduction or lip enhancement;
• Liposuction/lipofilling or body contouring or modeling of waist, buttocks, hips, and thighs reduction;
• Neck tightening;
• Pectoral implants;
• Reduction thyroid chondroplasty or trachea shaving (reduction of Adam's apple);
• Redundant/excessive skin removal;
• Rhinoplasty (nose correction);
• Skin resurfacing;

Benefits for gender reassignment surgery exclude:

- Transportation and lodging expenses
- Reversals

Human Organ and Tissue Transplants

The Plan pays for organ and tissue transplants (when performed in a Blue Cross Blue Shield-approved program), including the following:

- Heart;
- Lung;
- Heart/lung;
- Liver; and
- Pancreas or pancreas/kidney.

The Plan also pays benefits for the following human organ and tissue transplants:

- Cornea;
- Kidney;
- Bone marrow;

- Heart valve;
- Muscular-skeletal; and
- Parathyroid.

The Plan pays benefits for both the recipient and donor of the covered transplant as long as the following requirements are met:

- Both the donor and recipient each have coverage and their respective plans pay benefits.
- If you are the recipient and the donor does not have coverage from any other source, the Plan pays benefits for both you and the donor. The Plan pays for the donor and charges the benefits against your own.
- If you are the donor and coverage is not available to you from any other source, the Plan pays benefits for you. However, the Plan does not pay benefits for the recipient.

In addition, the Plan pays benefits for heart, lung, heart/lung, liver, pancreas or pancreas/kidney transplants as follows:

- If your *physician* recommends a heart, lung, heart/lung, liver, pancreas or pancreas/kidney transplant, you must call the *Claim Administrator* before your transplant *surgery* is scheduled. The *Claim Administrator* furnishes you with the names of *hospitals* that are approved through the program. If the transplant is performed at a *hospital* that's not approved through the program, the Plan does not pay benefits.
- The Plan offers a travel companion benefit, up to a maximum lifetime benefit equal to $10,000, which pays transportation and lodging costs for both the patient who is away from home to receive *medical care* and a companion. The facility must be at least 100 miles from the patient's home. Effective 1/1/11, the amount for lodging cannot be more than $50 per person per night. Meals are not allowed to be included in lodging expenses per IRS Code §213(d) **and IRS Publication 502.** Reimbursement will require submission of a qualifying receipt**.**

The Plan pays benefits for expenses related to the transportation of the donor organ to the actual location of the transplant surgery. To be eligible for benefits, transportation must take place within the United States or Canada.

In addition to the services listed under Expenses Not Covered, the Plan does not pay human organ transplant benefits for the following:

- Cardiac rehabilitation services provided more than three days after the recipient is discharged from the *hospital*;
- Transportation by air ambulance for the donor or the recipient;
- Travel time (and related expenses) required by a *provider*;
- Drugs which do not have approval of the Food and Drug Administration;
- Storage fees;
- Meals; or

- Services provided to any individual who is not the recipient or actual donor, unless otherwise specified in this provision.

Fertility Treatments

The diagnosis and/or treatment of infertility or to promote fertility, subject to a lifetime maximum of $15,000, including:

- In-vitro fertilization;
- Uterine embryo lavage;
- Embryo transfer;
- Artificial insemination;
- Gamete intra-fallopian tube transfer;
- Zygote intra-fallopian tube transfer;
- Low tubal ovum transfer; and
- Intracytoplasmic sperm injection.

Special Limitations

Benefits will not be provided for the following:

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

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

If you have ***family coverage***, the $15,000 lifetime maximum for ART is a family maximum.

Leg, back, arm and neck braces.

Medical and surgical dressings, supplies, casts and splints.

Mastectomies

Services related to mastectomies, including:

- Reconstruction of the breast on which the mastectomy has been performed;
- *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;
- *Surgery* and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and physical complications of all stages of the mastectomy (including lymphedemas).
- The removal of breast implants when the removal of the implants is a *medically necessary* treatment for a sickness or injury. *Surgery* performed for removal of breast implants that were implanted solely for cosmetic reasons are not covered. Cosmetic changes performed as reconstruction resulting from sickness or injury is not considered cosmetic *surgery*.

Naprapathic services

Benefits will be provided for naprapathic services when rendered by a naprapath. Benefits for naprapathic services shall be limited to 30 visits per benefit period.

Optometric Services

Optometric services for medical diagnosis, provided by a physician or optometrist (who legally renders services). These services are covered same as any other condition when the diagnosis indicates a medical condition. Benefits are paid at in or out of network levels, depending on the provider's eligibility.

Oxygen and its administration

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 services include teaching and monitoring of complex care skills such as tracheotomy suctioning, medical equipment use and monitoring to home caregivers and is not intended to provide for long term supportive care. Benefits for private duty nursing services will not be provided due to the lack of willing or available non-professional personnel.

The Plan limits private duty nursing services benefits to 15 visits per month.

Prosthetic appliances

Prosthetic appliances, prosthetic devices, special appliances and surgical implants when required to replace all or part of:

- An organ or tissue of the human body; or
- The function of a non-functioning or malfunctioning organ or tissue.

The Plan pays benefits for adjustments, as well as the charges associated with repair and replacement of a covered prosthetic device, special appliance or ***surgical*** implant (if a patient's condition changes or there's significant wear on the appliance). The Plan does not pay benefits for medical appliances (except for intra-oral devices used in connection with the ***temporomandibular joint dysfunction*** treatments), and the replacement of cataract lenses when a prescription change is not required.

Elective sterilization

(the Plan does not pay benefits for the reversal of sterilization).

The diagnosis and treatment of temporomandibular joint dysfunction and related medical disorders. The Plan limits benefits to $2,500 per lifetime.

Wigs. Benefits will be provided for wigs (also known as cranial prostheses) when your hair loss is due to chemotherapy, radiation therapy or alopecia.

Cranial orthotic devices for the treatment of nonsynostotic positional plagiocephaly. Your benefits for cranial orthotic devices will be limited to a lifetime maximum of $5,000.

Hearing Aids—Benefits will be provided for hearing aids for children limited to two every 36 months.

Autism Spectrum Disorders

Your benefits for the diagnosis and treatment of ***autism spectrum disorders*** are the same as your benefits for any other condition. Treatment for ***autism spectrum disorders*** shall include the following care when prescribed, provided or ordered for an individual diagnosed with an Autism Spectrum Disorder (a) by a ***physician*** or a ***psychologist*** who has determined that such care is ***medically necessary***, or (b) by a certified, registered or licensed health care professional with expertise in treating ***autism spectrum disorders*** and when such care is determined to be ***medically necessary*** and ordered by a ***physician*** or a ***psychologist***:

- psychiatric care, including diagnostic services;
- psychological assessments and treatments;
- habilitative or rehabilitative treatments;
- therapeutic care, including behavioral ***speech***, ***occupational*** and ***physical therapies*** that provide treatment in the following areas: a) self-care and feeding, b) pragmatic, receptive and expressive language, c) cognitive functioning, d) applied behavior analysis (ABA), intervention and modification, e) motor planning and f) sensory processing.

Mental Illness/Substance Use Disorder Services

The Plan pays benefits for the following ***mental illness*** and/or substance use disorder services.

Inpatient facility and physician services provided:

- In a hospital;
- In a substance use disorder treatment facility;
- In an intermediate care facility;
- Through a partial hospitalization (day/night) treatment program;
- In a virtual visit setting;
- By a physician;
- By a licensed clinical social worker;
- By a licensed clinical professional counselor; or by a *psychologist*; or
- By a marriage and family therapist.

The Plan considers an inpatient hospital stay to be one for which a room and board charge is made. Care provided in an intermediate care facility (intensive outpatient treatment) only includes continuous treatment of not less than three hours and not more than twelve hours in a 24-hour period. Intermediate care facility (intensive outpatient treatment) services do not include a hospital inpatient stay.

When determining the number of days for which benefits are payable, the Plan considers each day spent in an in-network ***hospital*** as two days of care at an ***intermediate care facility*** (intensive ***outpatient*** treatment). Each two days of care at an in-network ***intermediate care facility*** count as one day in an in-network ***hospital***.

Outpatient facility and physician services provided:

- In a hospital;
- Through a partial hospitalization (day/night) treatment program;
- By a physician;
- By a licensed clinical social worker;
- By a licensed clinical professional counselor; or
- By a psychologist.
- Via Skye

A $40 per-visit ***copayment*** applies for the Premier PPO and a $45 per-visit ***copayment*** applies for the Standard PPO to all in-network ***outpatient physician*** services related to ***mental illness*** or ***substance use disorder*** treatments. For the Health Savings Account plan, deductible and ***coinsurance*** apply.

Detoxification

Covered services received for detoxification are not subject to the Substance Use Disorder treatment provisions specified above. Benefits for ***covered services*** received for detoxification will be provided under the Hospital Benefits and Professional Services Benefits sections of this SPD, the same as for any other condition.

The services listed here are subject to all terms and conditions of the Plan. The Plan pays benefits only for ***eligible expenses*** that you (or your covered dependent) receive on or after your (or your

dependent's) coverage effective date. In addition, services must be ***medically necessary*** and provided upon the direction or under the direct care of your ***physician***.

Virtual Visit

Virtual Visit… means a service provided for the diagnosis or treatment of non-emergency behavioral health illness.

Virtual Provider

A Virtual Provider… means a licensed Provider who has a written agreement with the Claims Administrator to provider diagnosis and treatment illness through either i) interactive audio communication (via telephone or other similar technology) or ii) interactive audio/video examination and communication (via online portal, mobile application or similar technology) to you at the time services are rendered, operating within the scope of such license.

Medical Expenses Not Covered

The Plan does not pay benefits for all types of services, including those for the following:

Hospitalization, services, and supplies that are not medically necessary as determined by the Claim Administrator.

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

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

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

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

The ***Claim Administrator*** will make the decision whether hospitalization or other health care services or supplies were not ***medically necessary*** and therefore not eligible for payment under the terms of your health care plan.

In most instances this decision is made by the ***Claim Administrator*** AFTER YOU HAVE BEEN HOSPITALIZED OR HAVE RECEIVED OTHER HEALTH CARE SERVICES OR SUPPLIES AND AFTER A ***CLAIM*** FOR PAYMENT HAS BEEN SUBMITTED.

The fact that your ***physician*** may prescribe, order, recommend, approve or view hospitalization or other health care services and supplies as ***medically necessary*** does not make the hospitalization, services or supplies ***medically necessary*** and does not mean that the ***Claim 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 ***Claim Administrator's*** decision, the Plan provides for an appeal of that decision. See the "Claim Filing and Appeals Procedures" section below for details.

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

The following also are not payable under the Plan:

- Services or supplies not specifically listed as ***covered services***.
- An illness or injury that arises out of or in the course of employment and for which benefits are available under any Workers' Compensation Law or other similar laws (whether or not you make a claim for such compensation or receive such benefits).
- Services or supplies that are provided by or for which benefits are available from the local, state or federal government (for example, ***Medicare***) – whether or not benefits are received. Therefore, because this Plan, pursuant to its terms, will only pay benefits after determining what, if anything, ***Medicare*** would have paid/covered had you actually been "entitled" to ***Medicare*** Part A or "enrolled" in ***Medicare*** Part B, if you or a covered dependent are eligible for, but not entitled to or enrolled in, as applicable, benefits under ***Medicare***, you and your covered dependent (who is eligible for ***Medicare***) is encouraged to apply for and obtain coverage under ***Medicare*** as soon as you are eligible.
- Any illness or injury that occurs on or after your coverage effective date as a result of war or any act of war.
- Services or supplies that do not meet accepted standards of medical practice.
- ***Investigational services and supplies*** and all related services and supplies, except as may be provided under this SPD 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, if those services or supplies would otherwise be covered under this SPD if not provided in connection with a qualified cancer trial program and b) applied behavior analysis used for the treatment of ***autism spectrum disorders***.
- ***Custodial care services***
- Long Term Care
- Routine physical examinations, diagnostic testing and immunizations – unless otherwise specified under ***wellness care***.

- Services or supplies received on an ***inpatient*** basis as a result of behavioral, social maladjustment, lack of discipline or other antisocial actions which are not the result of ***mental illness***.
- Cosmetic ***surgery*** and related services and supplies (except for those to correct congenital deformities or conditions that result from an accidental medical injury, scar, tumor or disease).
- Services or supplies received from a medical or medical department or clinic that's maintained by an employer, labor union, or other similar person or group.
- Services or supplies for which you are not required to pay, or for which you'd have no legal obligations to pay if you did not have this or similar coverage.
- Charges you incur for failing to keep a scheduled visit or complete a ***claim*** form.
- Personal hygiene, comfort or convenience items that are commonly used for things other than medical purposes, including:
- Air conditioners;
- Humidifiers;
- Physical fitness equipment;
- Televisions; and
- Telephones.
- Special braces, splints, specialized equipment, appliances, ambulatory apparatus and battery implants (except those listed as ***covered services***).
- Prosthetic devices, special appliances, and ***surgical*** implants which are for cosmetic purposes, the comfort and convenience of the patient or unrelated to the treatment of an illness or injury.
- Blood derivatives which are not classified as drugs in the official formularies.
- Eyeglasses, contact lenses or cataract lenses, the examination for prescribing or fitting them, or for determining the refractive state of the eye (except as specifically listed as a ***covered service***).
- Foot treatments (except those that are specifically listed as a ***covered service***), including:
- Treatment of flat feet;
- The prescription of supportive devices for such conditions;
- The treatment of subluxations of the foot; and
- Routine foot care (except for those who are diagnosed with diabetes).
- Immunizations (except those specifically listed as a ***covered service***).
- ***Maintenance occupational, physical or speech therapy***.
- ***Speech therapy***, when rendered for the treatment of:
    - Psychosocial speech delay;

- Behavioral problems (including impulsive behavior and impulsivity syndrome);
- Attention disorders;
- Conceptual handicaps; or
- Mental retardation.
- Hearing aids or exams for prescribing or fitting them, unless otherwise specified as covered.
- Services and supplies, to the extent that benefits are duplicated because your ***spouse***, ***domestic partner*** and/or child are covered separately under the Plan.
- ***Diagnostic services*** that are part of routine physical exams or checkups, including:
    - Premarital examinations;
- Determination of the refractive errors of the eyes or auditory problems;
- Surveys, case findings, research studies, screenings, or similar procedures and studies or tests that are *investigational* in nature (unless otherwise listed as a *covered service*).
- Services and supplies that are rendered or provided for human organ or tissue transplants, other than those specifically listed as a ***covered service***.
- Reversal of sterilization.
- Gender Reassignment Surgery is covered; with the exception of the following:
    - Transportation and lodging expenses relating to gender reassignment surgery;
    - Reversals of gender reassignment surgery.
- ***Inpatient private duty nursing services***.
- ***Residential treatment centers***, except for ***inpatient*** Substance Use Disorders or ***inpatient mental illness*** as specifically mentioned in this SPD.

Medical Services Advisory (MSA) Program

The Medical Services Advisory (MSA) Program is designed to assist you in determining the ***course of treatment*** that will maximize your Plan benefits. Registered nurses and other personnel with clinical backgrounds staff the MSA Program, along with ***physicians*** in the medical department.

If you do not contact the MSA or comply with the MSA's determinations, the Plan reduces benefits. Please refer to your ID card for the MSA's toll-free number. Here's some important information regarding the MSA Program and its provisions.

Preadmission Review

The MSA Program provides review services for ***inpatient hospital***, emergency and maternity admissions. Preadmission review does not guarantee benefits. Benefit availability is subject to eligibility and other terms, conditions, limitations and exclusions of the Plan.

Inpatient Hospital Preadmission Review: If your physician recommends a non-emergency or non-maternity inpatient hospital admission, you must call the MSA to receive the maximum level of Plan benefits. You must call the MSA at least one business day before your hospital admission.

> If the MSA determines that your proposed ***hospital*** admission or health care service is not ***medically necessary***, the MSA refers your care to the ***Claim Administrator's physician*** for review. If the ***physician*** concurs that the proposed admission or health care is not ***medically necessary***, some days, services or the entire hospitalization may be denied benefits. The MSA advises the ***hospital*** and your ***physician*** of this determination by phone, and follows up with a notification letter. The MSA promptly sends the notification letter to you, your ***physician*** and the ***hospital***. However, in some instances, the letters are not received before your scheduled date of admission.

Emergency Admission Review: In the event of an emergency admission, you (or someone on your behalf) must call the MSA to receive the maximum level of Plan benefits. The call must be made no later than two business days after the admission. If the call is made any later than this, the Plan reduces benefits by $500.

Maternity Admission Review: In the event of a maternity admission, you (or someone on your behalf) must call the MSA to receive the maximum level of Plan benefits. The call must be made no later than 2 business days after admission. If the call is made any later than this, the Plan reduces benefits by $500.

Skilled Nursing Facility Preadmission Review: Skilled nursing facility preadmission review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of the Health Care Plan. Whenever an admission to a skilled nursing facility is recommended by your physician, in order to receive maximum benefits under this SPD, you must call the Claim Administrator's medical pre-notification number. This call must be made at least one business day prior to the scheduling of the admission.

Coordinated Home Care Program Preadmission Review: Coordinated home care program preadmission review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of the Health Care Plan.

> Whenever an admission to a ***coordinated home care program*** is recommended by your ***physician***, in order to receive maximum benefits under this SPD, you must call the ***Claim***

Administrator's medical pre-notification number. This call must be made at least one business day prior to the scheduling of the admission.

Private Duty Nursing Service Review: Private duty nursing service review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of the Health Care Plan. Whenever private duty nursing service is recommended by your physician, in order to receive maximum benefits under this SPD, you must call the Claim Administrator's medical pre-notification number. This call must be made at least one business day prior to receiving services.

Case Management

Case management is a collaborative process that assists you with the coordination of complex care services. A ***Claim Administrator*** case manager is available to you as an advocate for cost-effective interventions. Case managers are also available to you to provide assistance when you need alternative benefits. Alternative benefits will be provided only so long as the ***Claim Administrator*** determines that the alternative services are ***medically necessary*** and cost-effective. The total maximum payment for alternative services shall not exceed the total benefits for which you would otherwise be entitled under the Health Care Plan. Provision of alternative benefits in one instance shall not result in an obligation to provide the same or similar benefits in any other instance. In addition, the provision of alternative benefits shall not be construed as a waiver of any of the terms, conditions, limitations, and exclusions of the Health Care Plan.

Length of Stay/Service Review

Length of stay/service review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of the Health Care Plan. Upon completion of the preadmission or emergency review, the ***Claim Administrator*** will send a letter to your ***physician*** and/or the ***hospital*** confirming that you or your representative called the ***Claim Administrator*** and that an approved length of service or length of stay was assigned. An extension of the length of stay/service will be based solely on whether continued ***inpatient*** care or other health care service is ***medically necessary***. In the event that the extension is determined not to be ***medically necessary***, the authorization will not be extended. Additional notification will be provided to your ***physician*** and/or the ***hospital*** regarding the denial of payment for the extension.

Special Beginnings® Maternity Program

The Special Beginnings® Maternity program is a voluntary program for Publicis employees and their covered dependents. Through this program, Medical Service Advisory representatives monitor your pregnancy and provide educational materials. Enrollment in this program is optional.

How "Medically Necessary" is Determined

The MSA Program determines whether or not ***inpatient*** care or other health care services are ***medically necessary***. If the ***Claim Administrator's physician*** concurs that the ***inpatient*** care or other health care services or supplies are not ***medically necessary***, you, your ***physician*** and/or the ***hospital*** receive a written notification of the decision. The written notification includes the service dates for which the Plan does not pay benefits. See Medical Expenses Not Covered for details regarding what services are not eligible for benefits.

The MSA Program does not determine your ***course of treatment***, nor does it determine whether you should receive a particular health care service. You and your ***physician*** should decide together your ***course of treatment*** as well as the receipt of particular health care services. When the MSA Program determines whether or not care is ***medically necessary***, it limits its determination to whether a proposed admission, continued hospitalization, or other health care service is ***medically necessary*** under the Plan.

If the ***Claim Administrator*** determines that all or any portion of an ***inpatient*** hospitalization or other health care service is not ***medically necessary***, the Plan is not responsible for any related ***hospital*** or other health care service charge you may incur.

Please Note: The Plan does not pay benefits for a hospitalization or any other health care service or supply that's not ***medically necessary***. Just because your ***physician*** or health care ***provider*** may prescribe, order, recommend or approve a ***hospital*** stay or other health care service or supply does not in and of itself make such care ***medically necessary***. Therefore, even though your ***physician*** may prescribe, order, recommend, approve or view hospitalization or other health care services or supplies as ***medically necessary***, the ***Claim Administrator*** may not pay benefits for the hospitalization, service or supply if the MSA Program and the ***Claim Administrator's physician*** decide they are not ***medically necessary*** under the terms of the Plan.

The MSA Program's Procedures

When you (or someone on your behalf) call the MSA Program, be prepared to provide the following:

The name of the attending and/or admitting physician;

The name of the hospital and/or location where the admission is scheduled;

The scheduled admission and/or service date; and

A preliminary diagnosis or reason for the admission and/or service.

When you contact the MSA Program, representatives:

Review the medical information provided;

Follow up with the provider to confirm any missing details; and

Determine whether or not services are medically necessary.

To appeal the MSA Program's decisions, please see Claim Appeals Procedures in the Claim Filing and Appeals Procedures section.

If You Fail to Notify the MSA

The final decision regarding your ***course of treatment*** is solely your responsibility and the ***Claim Administrator*** will not interfere with your relationship with any ***provider***. However, the ***Claim Administrator*** has established the Utilization Review Program for the specific purpose of assisting you in determining the ***course of treatment*** which will maximize your benefits provided under this SPD.

Should you fail to notify the ***Claim Administrator*** as required in the Preadmission Review provision of this section, you will then be responsible for the first $500 of the ***hospital*** or facility charges for an eligible stay or $500 of the charges for ***skilled nursing facilities***, ***coordinated home care programs***, and ***private duty nursing service*** in addition to any deductibles, ***copayments*** and/or ***coinsurance*** applicable to this SPD. This amount shall not be eligible for

later consideration as an unreimbursed expense under any Benefit Section of this SPD nor can it be applied to your out-of-pocket expense limit, if applicable, as described in this SPD.

Applying for Benefits

As long as you receive care from a ***participating provider***, you do not have to file a ***claim*** form for benefits. However, if you go outside the network for care, you need to file a ***claim*** with the ***Claim Administrator*** before the Plan pays benefits. Please see the "Claim Filing and Appeals Procedures" section below for important information regarding filing and appealing ***claims***.

Claim forms are available from the Publicis Connections website (PublicisConnections.com) by accessing the Forms Library. Remember to take a form with you to your appointment with a ***non-participating provider***.

Your Prescription Drug Coverage

This section provides important information regarding your prescription drug benefits under the PPO and HSA Plans. If you select either PPO or HDHP with HSA medical option, you automatically receive prescription drug coverage.

This SPD, together with the Administrative Information Summary Plan Description, describes the basic features of your prescription drug coverage under the Medical and Prescription Drug Plan (as of the effective date of the SPD), how it operates and how you can get the maximum advantage from it. In setting forth the terms of the Plan on this site, every attempt has been made to make this summary as detailed and accurate as possible. However, if any statement made here disagrees with the plan provisions, the plan provisions will govern.

Snapshot of the Coverage

Your prescription drug coverage offers you choices as to how and where to get your prescriptions filled. For ***short-term prescriptions*** you have access to a retail pharmacy network. You also have access to mail-order service for long term medications. Both are designed to help you pay for your prescription drug expenses, and help the Plan better manage the escalating costs of such services.

Below is a snapshot of your prescription drug coverage. Remember, this is your coverage under either BCBS PPO option. Under the PPO plans the medial and prescription maximum out of pocket are integrated. This means, drug costs covered under your prescription drug benefit will now accumulate to satisfy a combined medial and prescription out of pocket maximum.

Type of Service	**Retail Pharmacy Network**	**Mail Order Service**
Coinsurance		
Generic	20% (Min: $10, Max: $50)	20% (Min: $25, Max: $125)
Formulary Brand	20% (Min: $35, Max: $100)	20% (Min: $75, Max: $250)
Non-Formulary Brand	20% (Min: $55, Max: $200)	20% (Min: $137.50, Max: $500)
Day Supply Limit		
The Maximum Amount You Can Receive Per Prescribed Order	34-day supply	90-day supply
Refill Limit		
The Maximum Amount You Can Receive Per Refill Order	Up to a 34-day supply You must also use 75% of your medication before you can obtain a refill	Up to a 90-day supply You must also use 75% of your medication before you can obtain a refill
When To Use		
Use For:	Short-term medications or immediate prescription drug needs	Long-term/maintenance medications should be filled by mail

Health Savings Account Option

Type of Service	**Retail Pharmacy Network**	**Mail Order Service**
Coinsurance		

Type of Service	Retail Pharmacy Network	Mail Order Service
Generic	20%, deductible applies	20%, deductible applies
Formulary Brand	20%, deductible applies	20%, deductible applies
Non-Formulary Brand	20%, deductible applies	20%, deductible applies
Day Supply Limit		
The Maximum Amount You Can Receive Per Prescribed Order	34-day supply	90-day supply
Refill Limit		
The Maximum Amount You Can Receive Per Refill Order	Up to a 34-day supply You must also use 75% of your medication before you can obtain a refill	Up to a 90-day supply You must also use 75% of your medication before you can obtain a refill
When To Use		
Use For:	Short-term medications or immediate prescription drug needs	Long-term/maintenance medications should be filled by mail

How Your Prescription Drug Coverage Works

In this document you'll find a brief overview of your coverage options, as well as how the features of your prescription drug coverage works.

About Your Coverage

The chart below gives a brief description of how the retail pharmacy network and mail order service operate.

Benefit	Retail Pharmacy Network	Mail-Order Service
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 need to fill your ***short-term prescription***, you decide whether to go to a participating or ***non-participating pharmacy***.	The mail-order service is designed to meet your ***long-term or maintenance medication*** needs.
Your Cost	If you fill your prescription at a ***participating pharmacy***, all you need to do is meet a ***coinsurance*** requirement. The Plan then pays the remaining cost of your prescription. See the snapshot chart for the ***coinsurance*** that applies for each type of prescription.	If you use the mail-order service, all you need to do is complete a CVS/Caremark Mail Service Order Form for your first mail service order and meet a ***coinsurance*** requirement. The Plan then mails you your ***long-term medication***. See the snapshot chart for the ***coinsurance*** that applies for each type of prescription.
What the Plan Pays	If you fill your prescription at a ***non-participating pharmacy***, the Plan pays 100% of the submitted price less the	The ***coinsurance*** requirement applies to each original prescription or refill.

Benefit	Retail Pharmacy Network	Mail-Order Service
	copayment through the paper claims process.	
Finding a Provider	You can select a ***participating pharmacy*** from a directory of ***participating pharmacies***. The complete list of ***participating pharmacies*** is furnished to you automatically and free of charge. You can also view a directory of ***participating pharmacies*** by logging into www.caremark.com, or you can call CVS Caremark at 1-866-212-4752.	Access mail-order information on the Prescription Drugs page of the Publicis Connections website. Forms are also available on the Guides/Forms page of the Publicis Connections website www.publicisbenefitsconnection.com.

While the directory of ***participating pharmacies*** under the PPO may change from time to time, the ***Claim Administrator*** continues to select ***participating pharmacies*** based on their range of services, geographic location and cost-effectiveness of care. If the directory changes, you are notified on an annual basis so that you may make a selection within the network. Even though a complete list of network ***providers*** is furnished to you automatically and free of charge, you may still want to call the ***Claim Administrator***, or visit the directory online at PublicisConnections.com on the Prescription Drugs page for the most up-to-date list of ***participating pharmacies*** or go directly to www.caremark.com. You can also check with your pharmacist before you fill your prescription to confirm the ***pharmacy*** is still participating.

Choosing Who to Cover

When you select your Medical Coverage option, you also decide whom to cover. This election also applies to your prescription drug coverage. As a result, the following coverage levels that you select from for your Medical Coverage also apply toward your prescription drug coverage:

- Employee Only;
- Employee Plus One; or
- Employee Plus Two or More.
- See the "Eligibility" section of this document for a complete description of which family members are eligible for coverage.

The Retail Pharmacy Network

Coverage for ***short-term prescriptions*** is available through the retail pharmacy network. Through this network, you can fill prescriptions at ***participating pharmacies*** after you meet a ***coinsurance*** requirement. The amount you pay depends on whether you receive a ***generic***, ***formulary brand***, or non-***formulary brand*** drug, and whether you get the prescription filled at one of the ***participating pharmacies***. See the Benefit at a Glance for details regarding the ***coinsurance*** requirements.

Below you'll find a brief overview of how to use the retail pharmacy network.

How to Use Participating Pharmacies

When you or a covered family member need a prescription filled, simply take it to a ***participating pharmacy***. A complete list of ***participating pharmacies*** is available online at PublicisConnections.com on the Prescription Drugs page or by calling CVS Caremark at 1-866-212-4752. This information is furnished to you automatically and free of charge. However, as the

network of ***participating pharmacies*** continues to grow, you may want to contact the ***Claim Administrator*** (the insurer) directly, or visit the online directory at www.caremark.com for an up-to-date list of ***participating pharmacies***.

Present your prescription and your ID card (you'll receive ID cards shortly after you enroll) to the pharmacist.

Make sure that your pharmacist has complete and correct information about you and your covered dependents.

Pay your required ***coinsurance*** payment. Your ***coinsurance*** may be lower if you have your prescription filled with ***generic*** or ***formulary brand*** drugs. You might ask your ***physician*** (or pharmacist) if your prescriptions may be filled with a ***generic*** instead of a ***formulary*** or non-***formulary brand*** drug.

Sign for and receive your prescription.

As long as you go to a ***participating pharmacy*** and pay the required ***coinsurance*** payment, you do not have to file a ***claim*** form for the Plan to pay benefits.

Refills

From time to time you may need to have your prescription refilled. If your ***physician*** authorizes a prescription refill, simply bring the prescription bottle or package to the ***participating pharmacy***. You may also use the pharmacy's automated refill system (if available).

Under the retail pharmacy network, the Plan limits refills to a 34-day supply. In addition, the Plan does not allow for you to refill your prescription until you use up at least 75% (based on the quantity and day-supply prescribed by your ***physician***) of your existing prescription.

The Mail-Order Service

For ***long-term medications*** you may use the mail-order service through www.caremark.com. With the mail-order service, you must meet a ***copayment*** requirement before you receive up to a 90-day supply of your medicine through the mail. The ***copayment*** applies to each original prescription or refill. The amount you pay depends on whether you receive a ***generic***, ***formulary brand***, or non-***formulary brand*** drug. See the snapshot chart for details regarding the ***copayment*** requirement.

In this document you'll find a brief overview of the mail-order service.

How to Use the Mail-Order Service

If you or your covered dependents participate in either PPO option and use ***long-term medications***, you can receive up to a 90-day supply of certain covered medications (refer to www.caremark.com). By using this service, By using this service, you can save money on your prescriptions..

To fill a prescription through the mail-order service:

Complete the CVS/Caremark Mail Service Order Form (available on the **Guides/Forms** page of PublicisConnections.com). A new order form and envelope also is then sent to you with each delivery.

If in the future you have additional information or changes to report, simply contact your local Human Resources Representative or the ***Claim Administrator***.

Have your physician write a new original prescription so that you can submit it directly to the mail-order service pharmacy with your Mail Service Order 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 extended supply (you can then submit this one to the mail-order service).

Make your check payable to CVS/Caremark or provide a credit card number (follow the instructions on the form). Please do not submit cash with your order.

The mailing address for CVS/Caremark to send your Prescription Order Form and check is:

CVS/Caremark
P.O. Box 2110
Pittsburgh, PA 15230-2110

You receive your mail-order prescription approximately 10 to 14 days from the date you mail your order.

Refills

From time to time you may need to have your ***long-term medication*** refilled. If your ***physician*** authorizes a prescription refill, simply submit your prescription to the mail-order service.

Under the mail-order service, the Plan limits refills to a 90-day supply. In addition, the Plan does not allow for you to refill your prescription until you use up at least 75% (based on the quantity and day-supply prescribed by your ***physician***) of your existing prescription.

Your ID Card

If you elect coverage for yourself, you receive one identification card. If you elect ***family coverage***, you'll receive an additional ID card in your name. You'll receive ID cards shortly after you enroll. The card tells you your identification number and is very important to obtain benefits. Please present your ID card when you visit a ***participating pharmacy***.

Covered Medications and Medical Devices

The Plan pays benefits for the following prescription drug medications and medical devices. The snapshot chart provides details as to how the Plan pays benefits for each medication, and a list of medications that are covered can be found at www.caremark.com. The snapshot chart also includes any limits that may apply. Covered prescription drug medications and medical devices consist of:

drugs which are self-administered that require, by federal law, a written prescription:

- self-injectable insulin and insulin syringes;
- diabetic supplies, as follows: test strips, glucagon emergency kits and lancets;
- contraceptive devices, injections, implants, consults, exam procedures and medical services in the office;
- infertility drugs.

Benefits for these drugs will be provided when:

- you have been given a written prescription for them by your *physician*, *dentist*, *optometrist* or *podiatrist* and
- you purchase the drugs from a *pharmacy* or from a *physician*, *dentist*, *optometrist* or *podiatrist* who regularly dispenses drug, and the drugs are self-administered.

Benefits will not be provided for:

- drugs used for cosmetic purposes (including, but not limited to, Minoxidil/Rogaine);
- Proton pump inhibitors
- any devices or appliances except as specifically mentioned above;
- any charges that you may incur for the drugs being administered to you.
- In addition, benefits will not be provided for any refills if the prescription is more than one year old.

The medications and devices listed here are subject to all terms and conditions described in this SPD. The Plan pays benefits only for ***eligible expenses*** that you (or your covered dependent) receive on or after your (or your dependent's) coverage effective date.

Be sure to reference the Glossary and the Prescriptions Not Covered areas for any limits and/or special conditions that pertain to your Plan benefits.

Medications and Medical Devices Not Covered

The Plan does not pay benefits for all types of prescription drug medications and medical devices, including those for the following:

Non-legend drugs, unless specified as a covered prescription.

Therapeutic devices for appliances (regardless of intended use, unless specified as a covered prescription), including:

- Support garments and other non-medicinal substances.

Charges for the administration or injection of any drug.

Drugs labeled "Caution limited by Federal law to investigational, or experimental drugs (even though a charge is made to the individual).

Medication which is to be taken by or administered to an individual (in whole or in part) while he or she is a patient in a hospital, rest home, sanitarium, extended care facility, convalescent hospital, nursing home, or similar institution which operates on its premises, or allows to be operated on its premises, a facility for dispensing pharmaceuticals.

Any prescription that's refilled in excess of the number specified by the physician, or any refill that's dispensed after one year from the physician's original order.

Minoxidil (Rogaine) for the treatment of alopecia.

Proton pump inhibitors

The Plan will cover a new drug, provided it's considered a ***legend drug*** that under the applicable state law may only be dispensed upon the written prescription of a ***physician*** or other lawful prescriber.

Prior Authorization Program

When certain medications and drug classes are prescribed, your ***physician*** will be required to obtain authorization from the ***Claim Administrator*** in order to receive benefits.

Your ***physician*** must send a letter to the ***Claim Administrator's*** prescription drug administrator explaining the reason for the prescription. The prescription drug administrator will review the letter and determine whether the reason for the prescription meets the criteria for ***medically necessary*** care. You and your ***physician*** will be notified of the prescription drug administrator's determination within 24-72 hours. No benefits will be provided for such drugs if prior authorization is not received.

You should refer to the formulary list, contact your ***pharmacy*** or refer to the ***Claim Administrator's*** website to determine which medications and drug classes require prior authorization.

Step Therapy

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

The ***Claim Administrator's*** prescription drug administrator will send a questionnaire to your ***physician*** upon your or your ***pharmacy's*** request. The questionnaire must be returned to the prescription drug administrator who will review the questionnaire and determine whether the reason for the prescription meets the criteria for ***medically necessary*** care.

To find out more about step therapy requirements or to determine which drugs or drug classes require step therapy, you should contact your ***pharmacy*** or refer to the Formulary Drug List by accessing the CVS Caremark website www.caremark.com or call Customer Service at 1-866-212-4752.

PrudentRx Copay Program for Specialty Medications

In order to provide a comprehensive and cost-effective prescription drug program for you and your family, Publicis Groupe has contracted with PrudentRx to offer the PrudentRx Copay Program for certain specialty medications. The PrudentRx Copay Program assists members by helping them enroll in manufacturer copay assistance programs. Medications in the specialty tier will be subject to a 30% co-insurance. However, enrolled members who get copay card for their specialty medication (if applicable), will have a $0 out-of-pocket responsibility for their prescriptions covered under the PrudentRx Copay Program.

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 Copay Program 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 medications included in the PrudentRx Program Drug List, you will receive a welcome letter and phone call from PrudentRx that provides specific information about the program as it pertains to your medication. All eligible members will be automatically enrolled in the PrudentRx program, but you can choose to opt out of the program. You must call 1-800-578-4403 to opt-out. Some manufacturers require you to sign up to take advantage of the copay assistance that they provide for their medications – in that case, you must speak to someone at PrudentRx at 1-800-578-4403 to provide any additional information needed to enroll in the copay program. PrudentRx will also contact you if you are required to enroll in the copay assistance for any medication that you take. If you do not return their call, choose to opt-out of the program, or if you do not affirmatively enroll in any copay assistance as required by a manufacturer you will be responsible for the full amount of the 30% co-insurance on specialty medications that are eligible for the PrudentRx program.

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

The PrudentRx Program Drug List may be updated periodically by the Plan.

Copayments for these medications, whether made by you, your plan, or a manufacturer's copay assistance program, will not count toward your plan deductible.

Because certain specialty medications do not qualify as "essential health benefits" under the Affordable Care Act, member cost share payments for these medications, whether made by you or a manufacturer copayment assistance program, do not count towards the Plan's out-of-pocket maximum. A list of specialty medications that are not considered to be "essential health benefits" is available. An exception process is available for determining whether a medication that is not an essential health benefit is medically necessary for a particular individual.

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

Applying for Benefits

As long as you receive care from a ***participating pharmacy***, you do not have to file a ***claim*** form for benefits. However, if you go outside the network to fill your prescription, the Plan pays 100% of the submitted price less the Copayment through the paper claims process. Please see the "Claim Filing and Appeals Procedures" section below for important information regarding filing and appealing ***claims***.

ERISA Rights

As a participant in the group benefit plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974. ERISA provides that all plan participants shall be entitled to:

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites, all documents governing the Plan, including insurance contracts and a copy of the latest annual report (Form 5500 Series) that is filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

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

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

Receive a copy of the procedures used by the Plan for determining a qualified medical child support order upon request.

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

Please refer to the Administrative Information Summary Plan Description for specific ERISA information regarding your Benefit Plans.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

If your ***claim*** for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the ***Plan Administrator*** to provide the materials and pay up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator.

If you have a ***claim*** for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the status of a domestic relations order or a medical child support order, you may file suit in a federal court.

Terms in *bold/italics* are further defined in the Glossary

If it should happen that plan fiduciaries misuse the Plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your plan, you should contact the ***Plan Administrator*** at:

Publicis Re:Sources USA
Publicis Benefits Department
Attn: Plan Administrative Committee
35 West Wacker Drive
Chicago, IL 60601
1-800-933-3622

If you have any questions about this statement or about your rights under ERISA, including COBRA, HIPAA, and other laws affecting the Plan or need assistance in obtaining documents from the Plan Administrator, you should contact:

The nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory; or

The Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

The ***Plan Administrator*** has delegated to the ***Claim Administrator*** the discretionary authority to make decisions regarding the interpretation or application of Plan provisions, to make determinations (including factual determinations) as to the rights and benefits of employees and participants under the Plan, to make ***claims*** determinations under the Plan and to decide the appeal of denied ***claims***. Benefits will be paid under the Plan only if the ***Plan Administrator***, or its delegate, determines that the claimant is entitled to them. The decision of the ***Plan Administrator*** or its delegate is final and binding.

Additional Information

Any information or notice which you must furnish to the ***Claim Administrator*** under the Plan as described here must be in writing and sent to the ***Claim Administrator*** at its offices located at:

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

Any information or notice that the ***Claim Administrator*** furnishes to you must be in writing and sent to your address on file, or in care of Publicis Connections Benefits Department (or in the case of a divorce decree, to the designated representative as it appears on the ***Claim Administrator's*** records).

HIPAA

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. Pursuant to the HIPAA privacy rules, the Plan will not use or disclose your protected health information without your authorization, except for purposes of treatment, payment, health care operations, Plan administration or as required or permitted by law. A description of the Plan's uses and disclosures of your protected health information and your rights and protections under the HIPAA privacy rules is set forth in the plan's Notice of Privacy Practices, which is furnished to all Plan participants and can also be accessed on the Plan's internet site at: PublicisConnections.com.

Claim Filing and Appeals Procedures

In order to obtain your benefits under this benefit program, it is necessary for a ***claim*** to be filed with the ***Claim Administrator***. To file a ***claim***, usually all you will have to do is show your ID card to your ***hospital*** or ***physician*** (or other ***provider***). They will file your ***claim*** for you. Remember however, it is your responsibility to ensure that the necessary ***claim*** information has been provided to the ***Claim Administrator***.

Once the ***Claim Administrator*** receives your ***claim***, it will be processed and the benefit payment will usually be sent directly to the ***hospital*** or ***physician***. You will receive a statement telling you how your benefits were calculated. In some cases the ***Claim Administrator*** will send the payment directly to you or if applicable, in the case of a Qualified Medical Child Support Order, to the designated representative as it appears on the ***Claim Administrator's*** records.

In certain situations, you will have to file your own ***claims***. This is primarily true when you are receiving services or supplies from ***providers*** other than a ***hospital*** or ***physician***. An example would be when you have had ambulance expenses. To file your own benefit ***claim***, follow these instructions:

1. Complete a ***claim*** form. These are available from the Publicis Connections website or from the ***Claim Administrator's*** website.
2. Attach copies of all bills to be considered for benefits. These bills must include the ***provider's*** name and address, the patient's name, the diagnosis, the date of service and a description of the service and the ***claim charge***.
3. Mail the completed ***claim*** form with attachments to:

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

In any case, ***claims*** should be filed with the ***Claim Administrator*** on or before December 31st of the calendar year following the year in which your ***covered service*** was rendered. ***Claims*** not filed within the required time period will not be eligible for payment.

If you have a ***claim*** that does not directly involve a benefit payment (such as a determination as to whether you are eligible for the Plan), or the ***Claim Administrator*** indicates your ***claim*** is not a ***claim*** for benefits, you should make your claim by contacting the ***Plan Administrator*** at:

Publicis Connections
Attn: Plan Administrative Committee
35 West Wacker Drive
Chicago, IL 60601
1-800-933-3622

The ***Plan Administrator*** will evaluate your ***claim*** and apply procedures that are appropriate to the type of ***claim*** (such as procedures similar to those for life insurance claims under the Plan) and consistent with U.S. Department of Labor regulations and will inform you of those procedures.

If you have any questions regarding the filing of ***claims***, contact the Publicis Re:Sources USA Benefits Department or the ***Claim Administrator***.

Filing Outpatient Prescription Drug Claims

In certain situations, you will have to file your own ***claims*** in order to obtain benefits for ***outpatient*** prescription drugs. This is primarily true when you did not receive an identification card, the ***pharmacy*** was unable to transmit a ***claim*** or you received benefits from a ***non-participating pharmacy***. To do so, follow these instructions:

1. Complete a prescription drug ***claim*** form. These forms are available from PublicisConnections.com or from www.caremark.com.
2. Attach copies of all ***pharmacy*** receipts to be considered for benefits. These receipts must be itemized.
3. Mail the completed ***claim*** form with attachments to:

   CVS/Caremark
   P.O. Box 52136
   Phoenix, AZ 85072

In any case, ***claims*** must be filed no later than one year after the date a service is received. ***Claims*** not filed within one year from the date a service is received will not be eligible for payment.

Internal Claims Determinations and Appeals Process

Initial Claims Determinations

The ***Claim Administrator*** will usually pay all ***claims*** within 30 days of receipt of all information required to process a ***claim***. The ***Claim Administrator*** will usually notify you, your valid assignee or your authorized representative, when all information required to pay a ***claim*** within 30 days of the ***claim's*** receipt has not been received. (For information regarding assigning benefits, see "Payment of Claims and Assignment of Benefits" provisions below.) If you fail to follow the procedures for filing a pre–service ***claim*** (as defined below), you will be notified within 5 days (or within 24 hours in the case of a failure regarding an urgent care/expedited clinical ***claim*** as defined below). Notification may be oral unless the claimant requests written notification.

Payment of Claims and Assignment of Benefits

The ***Claim Administrator*** has the right to make any benefit payment either to you or directly to the ***provider*** of the ***covered services***. For example, the ***Claim Administrator*** may pay benefits to you if you receive ***covered services*** from a ***non-administrator provider***. The ***Claim Administrator*** is specifically authorized by you to determine to whom any benefit payment should be made.

Once ***covered services*** are rendered by a ***provider***, you have no right to request the ***Claim Administrator*** not to pay the ***claim*** submitted by such ***provider*** and no such request will be given effect. In addition, the ***Claim Administrator*** will have no liability to you or any other person because of its rejection of such request.

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

Program is expressly non-assignable and non-transferable and will be forfeited if you attempt to assign or transfer coverage or aid or attempt to aid any other person in fraudulently obtaining coverage. Any such assignment or transfer of a ***claim*** for benefits or coverage shall be null and

void. Allowing a ***provider*** to submit a ***claim*** on your behalf is not an assignment; the submitting ***provider*** is merely acting on your behalf and has no separate right to collect any amount under the Plan.

Special Cases: Value-Based Programs

If you receive Covered Services under a Value-Based Program inside a Host Blue's service area, you will not be responsible for paying any of the Provider Incentives, risk-sharing and/or Care Coordinator Fees that are a part of such an arrangement, except when Host Blue passes these fees to the Plan through average or fee schedule adjustments.

If a Claim Is Denied or Not Paid in Full

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

- For non–urgent pre–service ***claims***, within 15 days after receipt of the ***claim*** by the ***Claim Administrator***. A "pre–service ***claim***" is any non–urgent request for benefits or for a determination, with respect to which the terms of the benefit plan condition receipt of the benefit on approval of the benefit in advance of obtaining ***medical care***.
- For post–service ***claims***, within 30 days after receipt of the ***claim*** by the ***Claim Administrator***. A "post–service ***claim***" is a ***claim*** that is not a pre-service ***claim*** as defined above.

If the ***Claim Administrator*** determines that special circumstances require an extension of time for processing the ***claim***, for non–urgent pre–service and post–service ***claims***, the ***Claim Administrator*** will notify you or your authorized representative in writing of the need for extension, the reason for the extension, and the expected date of decision within the initial period. In no event shall such extension exceed 15 days from the end of such initial period.

If an extension is necessary because additional information is needed from you, the notice of extension shall also specifically describe the missing information, and you shall have at least 45 days from receipt of the notice within which to provide the requested information.

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

- The reasons for denial;
- A reference to the benefit plan provisions on which the denial is based;
- A description of additional information which may be necessary to perfect an appeal and an explanation of why such material is necessary;
- Subject to privacy laws and other restrictions, if any, the identification of the ***claim***, date of service, health care ***provider***, ***claim*** amount (if applicable), diagnosis, treatment and denial codes with their meanings and the standards used;
- An explanation of the ***Claim Administrator's*** internal review/appeals and external review processes (and how to initiate a review/appeal or external review) and a statement of your right, if any, to bring a civil action under Section 502(a) of ERISA following a final denial on internal review/appeal;
- In certain situations, a statement in non–English language(s) that future notices of ***claim*** denials and certain other benefit information may be available in such non–English language(s);
- The right to request, free of charge, reasonable access to and copies of all documents, records and other information relevant to the ***claim*** for benefits;

- The right to request, free of charge, reasonable access to and copies of all documents, records and other information relevant to the ***claim*** for benefits;
- Any internal rule, guideline, protocol or other similar criterion relied on in the determination, and a statement that a copy of such rule, guideline, protocol or other similar criterion will be provided free of charge on request;
- An explanation of the scientific or clinical judgment relied on in the determination as applied to claimant's medical circumstances, if the denial was based on medical necessity, ***experimental*** treatment or similar exclusion, or a statement that such explanation will be provided free of charge upon request;
- In the case of a denial of an urgent care/expedited clinical ***claim***, a description of the expedited review procedure applicable to such ***claims***. An urgent care/expedited ***claim*** decision may be provided orally, so long as written notice is furnished to the claimant with 3 days of oral notification;
- Contact information for any applicable office of health insurance consumer assistance or ombudsman.

3. For benefit determinations relating to urgent care/expedited clinical ***claim*** (as defined below), such notice will be provided no later than 24 hours after the receipt of your ***claim*** for benefits, unless you fail to provide sufficient information. You will be notified of the missing information and will have no less than 48 hours to provide the information. A benefit determination will be made within 48 hours after the missing information is received.
4. For benefit determinations relating to care that is being received at the same time as the determination, such notice will be provided no later than 24 hours after receipt of your ***claim*** for benefits.

An "urgent care/expedited clinical ***claim***" is any pre–service ***claim*** for benefits for ***medical care*** or treatment with respect to which the application of regular time periods for making health ***claim*** decisions could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function or, in the opinion of a ***physician*** with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment.

Inquiries and Complaints

An **"Inquiry"** is a general request for information regarding ***claims***, benefits, or membership.

A **"Complaint"** is an expression of dissatisfaction by you either orally or in writing.

The ***Claim Administrator*** has a team available to assist you with Inquiries and Complaints. Issues may include, but are not limited to, the following:

- ***Claims***
- Quality of care

When your Complaint relates to dissatisfaction with a ***claim*** denial (or partial denial), then you have the right to a ***claim*** review/appeal as described in the Claim Appeal Procedures. To pursue an Inquiry or a Complaint, you may contact **Customer Service** at the number on the back of your ID card, or you may write to:

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

Any Inquiry or Complaint will not be treated as either a ***claim*** or an appeal for review of an Adverse Benefit Determination (as defined below). Instead, when you contact Customer Service to pursue an Inquiry or Complaint, you will receive a written acknowledgement of your call or correspondence. You will receive a written response to your Inquiry or Complaint within 30 days of receipt by Customer Service. Sometimes the acknowledgement and the response will be combined. If the ***Claim Administrator*** needs more information, you will be contacted. If a response to your Inquiry or Complaint will be delayed due to the need for additional information, you will be contacted.

In contrast, an appeal is a specific oral or written request for review of an Adverse Benefit Determination (as defined below) or an adverse action by the ***Claim Administrator***, its employees or a ***participating provider***.

Claim Appeal Procedures – Definitions

An appeal of an Adverse Benefit Determination may be filed by you or a person authorized to act on your behalf. In some circumstances, a health care ***provider*** may appeal on his/her own behalf. Your designation of a representative must be in writing as it is necessary to protect against disclosure of information about you except to your authorized representative. To obtain an Authorized Representative Form, you or your representative may call the ***Claim Administrator*** at the number on the back of your ID card.

An **"Adverse Benefit Determination"** means a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment for, a benefit resulting from the application of utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be ***investigational*** or ***experimental*** or not ***medically necessary*** or appropriate. If an ongoing ***course of treatment*** had been approved by the ***Claim Administrator*** or ***Plan Administrator*** and the ***Claim Administrator*** or the ***Company*** reduces or terminates such treatment (other than by amendment or termination of the Program) before the end of the approved treatment period that is also an Adverse Benefit Determination. A rescission of coverage is also an Adverse Benefit Determination. A rescission does not include a termination of coverage for reasons related to non–payment of premium or contributions.

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

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

Claim Appeal Procedures

If you have received an Adverse Benefit Determination, you may have your ***claim*** reviewed on appeal. The ***Claim Administrator*** will review its decision in accordance with the following procedures. The following review procedures will also be used for ***Claim Administrator's*** (i)

coverage determinations that are related to non–urgent care that you have not yet received if approval by your plan is a condition of your opportunity to maximize your benefits and (ii) coverage determinations that are related to care that you are receiving at the same time as the determination. ***Claim*** reviews are commonly referred to as "appeals."

Within 180 days after you receive notice of an Adverse Benefit Determination, you may call or write to the ***Claim Administrator*** to request a ***claim*** review. The ***Claim Administrator*** will need to know the reasons why you do not agree with the Adverse Benefit Determination. You may call 1–877–284–9302 or send your request to:

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

In support of your ***claim*** review, you have the option of presenting evidence and testimony to the ***Claim Administrator***, by phone or in person at a location of the ***Claim Administrator's*** choice. You and your authorized representative may ask to review your file and any relevant documents and may submit written issues, comments and additional medical information within 180 days after you receive notice of an Adverse Benefit Determination or at any time during the ***claim*** review process.

The ***Claim Administrator*** will provide you or your authorized representative with any new or additional evidence or rationale and any other information and documents used in the denial or the review of your ***claim*** without regard to whether such information was considered in the initial determination. No deference will be given to the initial Adverse Benefit Determination. Such new or additional evidence or rationale and information will be provided to you or your authorized representative sufficiently in advance of the date a final decision on appeal is made in order to give you a chance to respond. The appeal will be conducted by individuals associated with the ***Claim Administrator*** and/or by external advisors, but who were not involved in making the initial denial of your ***claim***. Before you or your authorized representative may bring any action to recover benefits the claimant much exhaust the appeal process and must raise all issues with respect to a ***claim*** and must file an appeal or appeals and the appeals must be finally decided by the ***Claim Administrator*** or ***Plan Administrator***.

Urgent Care/Expedited Clinical Appeals

If your appeal relates to an urgent care/expedited clinical ***claim***, or health care services, including but not limited to, procedures or treatments ordered by a health care ***provider***, the denial of which could significantly increase the risk to the claimant's health, then you may be entitled to an appeal on an expedited basis. Before authorization of benefits for an ongoing ***course of treatment*** is terminated or reduced, the ***Claim Administrator*** will provide you with notice at least 24 hours before the previous benefits authorization ends and an opportunity to appeal. For the ongoing ***course of treatment***, coverage will continue during the appeal process.

Upon receipt of an urgent care/expedited pre–service or concurrent clinical appeal, the ***Claim Administrator*** will notify the party filing the appeal, as soon as possible, but no more than 24 hours after submission of the appeal, of all the information needed to review the appeal. Additional information must be submitted within 24 hours of request. The ***Claim Administrator*** will render a determination on the appeal within 24 hours after it receives the requested information.

Other Appeals

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

If You Need Assistance

If you have any questions about the ***claims*** procedures or the review procedure, write or call the ***Claim Administrator*** headquarters at 1–800–538–8833. The ***Claim Administrator*** offices are open from 8:45 A.M. to 4:45 P.M., Monday through Friday.

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

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

Notice of Appeal Determination

The ***Claim Administrator*** will notify the party filing the appeal, you, and, if a clinical appeal, any health care ***provider*** who recommended the services involved in the appeal, orally of its determination followed–up by a written notice of the determination.

If your ***claim*** is denied on review, the written notice will include:

1. The reasons for the adverse determination;
2. A reference to the benefit plan provisions on which the adverse determination is based, or the contractual, administrative or protocol for the determination;
3. Subject to privacy laws and other restrictions, if any, the identification of the ***claim***, date of service, health care ***provider***, ***claim*** amount (if applicable), and information about how to obtain diagnosis, treatment and denial codes with their meanings;
4. An explanation of the ***Claim Administrator's*** external review processes (and how to initiate an external review) and a statement of your right, if any, to bring a civil action under Section 502(a) of ERISA following a final denial on external appeal;
5. In certain situations, a statement in non–English language(s) that future notices of ***claim*** denials and certain other benefit information may be available in such non–English language(s);
6. The right to request, free of charge, reasonable access to and copies of all documents, records and other information relevant to the ***claim*** for benefits;
7. Any internal rule, guideline, protocol or other similar criterion relied on in the determination, or a statement that a copy of such rule, guideline, protocol or other similar criterion will be provided free of charge on request;
8. An explanation of the scientific or clinical judgment relied on in the adverse determination, or a statement that such explanation will be provided free of charge upon request;

9. A description of the standard that was used in denying the ***claim*** and a discussion of the decision.

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

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

You must exercise the right to internal appeal as a precondition to taking any action against the ***Claim Administrator***, either at law or in equity. If you have an adverse appeal determination, you may file civil action under Section 502(a) of ERISA in a state or federal court.

Plan Administrative Committee Voluntary Appeal

If you are not satisfied with the appeal decision at the ***Claim Administrator*** (Blue Cross Blue Shield), you have the right to request an appeal from the Plan Administrative Committee within 60 days from receipt of the Blue Cross Blue Shield appeal determination. Upon receipt of a non–urgent pre–service or post–service appeal the Plan Administrative Committee will render a determination of the appeal within 30 days after the appeal has been received.

Plan Administrative Committee appeals should be in writing and sent to:

Publicis Connections
Attn: Plan Administrative Committee
35 W. Wacker Dr., 12th Floor
Chicago, IL 60601

Please note plan participants may submit a written request to examine ***claim*** and/or appeals documents free of charge. The Plan Administrative Committee will review all ***claims*** in accordance with the rules established by the U.S. Department of Labor. Decisions on appeals by the Plan Administrative Committee will be final.

Independent External Review

You or your authorized representative (as described above) may make a request for a standard external review or, under certain circumstances, an expedited external review of an Adverse Benefit Determination or Final Internal Adverse Benefit Determination by an independent review organization (IRO). Please note an IRO review is not available for non-benefits ***claims*** such as ***claims*** for eligibility or out of network benefits.

Standard External Review

1. **Request for external review.** Within 4 months after the date of receipt of a notice of an Adverse Benefit Determination or Final Internal Adverse Benefit Determination from the ***Claim Administrator***, you or your authorized representative must file your request for standard external review. If there is no corresponding date 4 months after the date of receipt of such a notice, then the request must be filed by the first day of the fifth month following the receipt of the notice. For example, if the date of receipt of the notice is October 30, because there is no February 30, the request must be filed by March 1. If the last filing date

would fall on a Saturday, Sunday, or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or Federal holiday.

2. **Preliminary review.** Within 5 business days following the date of receipt of the external review request, the ***Claim Administrator*** must complete a preliminary review of the request to determine whether:

    - You are, or were, covered under the plan at the time the health care item or service was requested or, in the case of a retrospective review, were covered under the plan at the time the health care item or service was provided;
    - The Adverse Benefit Determination or the Final Adverse Benefit Determination does not relate to your failure to meet the requirements for eligibility under the terms of the plan (e.g., worker classification or similar determination);
    - You have exhausted the ***Claim Administrator's*** internal appeal process unless you are not required to exhaust the internal appeals process under the interim final regulations. Please read the Exhaustion section below for additional information and exhaustion of the internal appeal process; and
    - You or your authorized representative has provided all the information and forms required to process an external review.

    You will be notified within 1 business day after we complete the preliminary review if your request is eligible or if further information or documents are needed. You will have the remainder of the 4–month appeal period (or 48 hours following receipt of the notice), whichever is later, to perfect the appeal request. If your ***claim*** is not eligible for external review, we will outline the reasons it is ineligible in the notice, and provide contact information for the Department of Labor's Employee Benefits Security Administration (toll–free number 866–444–EBSA (3272).

3. **Referral to Independent Review Organization.** When an eligible request for external review is completed within the time period allowed, ***Claim Administrator*** will assign the matter to an independent review organization (IRO). The IRO assigned will be accredited by URAC or by similar nationally-recognized accrediting organization. Moreover, the ***Claim Administrator*** will take action against bias and to ensure independence. Accordingly, the ***Claim Administrator*** must contract with at least three IROs for assignments under the Plan and rotate ***claims*** assignments among them (or incorporate other independent, unbiased methods for selection of IROs, such as random selection). In addition, the IRO may not be eligible for any financial incentives based on the likelihood that the IRO will support the denial of benefits.

    The IRO must provide the following:

    - Utilization of legal experts where appropriate to make coverage determinations under the plan.
    - Timely notification to you or your authorized representative, in writing, of the request's eligibility and acceptance for external review. This notice will include a statement that you may submit in writing to the assigned IRO within ten business days following the date of receipt of the notice additional information that the IRO must consider when conducting the external review. The IRO is not required to, but may, accept and consider additional information submitted after 10 business days.

- Within 5 business days after the date of assignment of the IRO, the ***Claim Administrator*** must provide to the assigned IRO the documents and any information considered in making the Adverse Benefit Determination or Final Internal Adverse Benefit Determination. Failure by the ***Claim Administrator*** to timely provide the documents and information must not delay the conduct of the external review. If the ***Claim Administrator*** fails to timely provide the documents and information, the assigned IRO may terminate the external review and make a decision to reverse the Adverse Benefit Determination or Final Internal Adverse Benefit Determination. Within 1 business day after making the decision, the IRO must notify the ***Claim Administrator*** and you or your authorized representative.
- Upon receipt of any information submitted by you or your authorized representative, the assigned IRO must within 1 business day forward the information to the ***Claim Administrator***. Upon receipt of any such information, the ***Claim Administrator*** may reconsider its Adverse Benefit Determination or Final Internal Adverse Benefit Determination that is the subject of the external review. Reconsideration by the ***Claim Administrator*** must not delay the external review. The external review may be terminated as a result of the reconsideration only if the ***Claim Administrator*** decides, upon completion of its reconsideration, to reverse its Adverse Benefit Determination or Final Internal Adverse Benefit Determination and provide coverage or payment. Within 1 business day after making such a decision, the ***Claim Administrator*** must provide written notice of its decision to you and the assigned IRO. The assigned IRO must terminate the external review upon receipt of the notice from the ***Claim Administrator***.
- Review all of the information and documents timely received. In reaching a decision, the assigned IRO will review the ***claim*** *de novo* and not be bound by any decisions or conclusions reached during the ***Claim Administrator's*** internal claims and appeals process applicable under paragraph (b) of the interim final regulations under section 2719 of the Public Health Service (PHS) Act. In addition to the documents and information provided, the assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the following in reaching a decision:
    - Your medical records;
    - The attending health care professional's recommendation;
    - Reports from appropriate health care professionals and other documents submitted by the ***Claim Administrator***, you, or your treating ***provider***;
    - The terms of your plan to ensure that the IRO's decision is not contrary to the terms of the plan, unless the terms are inconsistent with applicable law;
    - 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 ***Claim Administrator***, unless the criteria are inconsistent with the terms of the plan or with applicable law; and
    - The opinion of the IRO's clinical reviewer or reviewers after considering information described in this notice to the extent the information or documents are available and the clinical reviewer or reviewers consider appropriate.

- Written notice of the final external review decision must be provided within 45 days after the IRO receives the request for the external review. The IRO must deliver the notice of final external review decision to the ***Claim Administrator*** and you or your authorized representative.
- The notice of final external review decision will contain:
    - A general description of the reason for the request for external review, including information sufficient to identify the ***claim*** (including the date or dates of service, the health care ***provider***, the ***claim*** amount (if applicable), the diagnosis code and its corresponding meaning, the treatment code and its corresponding meaning, and the reason for the previous denial);
    - The date the IRO received the assignment to conduct the external review and the date of the IRO decision;
    - References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;
    - A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;
    - A statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to either the ***Claim Administrator*** and you or your authorized representative;
    - A statement that judicial review may be available to you or your authorized representative; and
    - Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under PHS Act section 2793.
- After a final external review decision, the IRO must maintain records of all ***claims*** and notices associated with the external review process for six years. An IRO must make such records available for examination by the ***Claim Administrator***, State or Federal oversight agency upon request, except where such disclosure would violate State or Federal privacy laws, and you or your authorized representative.

4. **Reversal of plan's decision.** Upon receipt of a notice of a final external review decision reversing the Adverse Benefit Determination or Final Internal Adverse Benefit Determination, the ***Claim Administrator*** immediately must provide coverage or payment (including immediately authorizing or immediately paying benefits) for the ***claim***.

Expedited External Review

1. **Request for expedited external review.** The ***Claim Administrator*** must allow you or your authorized representative to make a request for an expedited external review with the ***Claim Administrator*** at the time you receive:

    a. An Adverse Benefit Determination if the Adverse Benefit Determination involves a medical condition of the claimant for which the timeframe for completion of an expedited internal appeal under the interim final regulations would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function and you have filed a request for an expedited internal appeal; or

b. A Final Internal Adverse Benefit Determination, if the claimant has a medical condition where the timeframe for completion of a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, or if the Final Internal Adverse Benefit Determination concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, but have not been discharged from a facility.

2. **Preliminary review.** Immediately upon receipt of the request for expedited external review, the ***Claim Administrator*** must determine whether the request meets the reviewability requirements set forth in the Standard External Review section above. The ***Claim Administrator*** must immediately send you a notice of its eligibility determination that meets the requirements set forth in Standard External Review section above.
3. **Referral to independent review organization.** Upon a determination that a request is eligible for external review following the preliminary review, the ***Claim Administrator*** will assign an IRO pursuant to the requirements set forth in the Standard External Review section above. The ***Claim Administrator*** must provide or transmit all necessary documents and information considered in making the Adverse Benefit Determination or Final Internal Adverse Benefit Determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method.

   The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the information or documents described under the STANDARD EXTERNAL REVIEW section above. In reaching a decision, the assigned IRO must review the ***claim*** *de novo* and is not bound by any decisions or conclusions reached during the ***Claim Administrator's*** internal claims and appeals process.
4. **Notice of final external review decision.** The ***Claim Administrator's*** contract with the assigned IRO must require the IRO to provide notice of the final external review decision, in accordance with the requirements set forth in the Standard External Review section above, as expeditiously as your medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within 48 hours after the date of providing that notice, the assigned IRO must provide written confirmation of the decision to the ***Claim Administrator*** and you or your authorized representative.

Exhaustion

For standard internal review, you have the right to request external review once the internal review process has been completed and you have received the Final Internal Adverse Benefit Determination. For expedited internal review, you may request external review simultaneously with the request for expedited internal review. The IRO will determine whether or not your request is appropriate for expedited external review or if the expedited internal review process must be completed before external review may be requested.

You will be deemed to have exhausted the internal review process and may request external review if the ***Claim Administrator*** waives the internal review process or the ***Claim Administrator*** has failed to comply with the internal claims and appeals process. In the event you have been deemed to exhaust the internal review process due to the failure by the ***Claim Administrator*** to comply with the internal claims and appeals process, you also have the right to pursue any available remedies under Section 502(a) of ERISA.

External review may not be requested for an Adverse Benefit Determination involving a ***claim*** for benefits for a health care service that you have already received until the internal review process has been exhausted.

Limitation on Legal Action Against the Plan

You may not commence any legal action, including a court proceeding under Section 502(a) of ERISA, prior to the completion of all the administrative proceedings described above. Also, even if there are other periods to commence an action prescribed by law or rule of a court or other forum, no action in any forum to enforce benefits or other rights under the Plan may be undertaken more than one year following the date you are notified of the final decision on appeal. If the ***Claim Administrator*** or ***Plan Administrator*** considers a ***claim***, in whole or in part, after any period for action described above has elapsed, it is not waiving the Plan's rights to limit legal actions thereafter.

Glossary of Terms

A1C Testing

Means blood sugar level testing used to diagnose prediabetes, type I diabetes, and type II diabetes, and to monitor management of blood sugar levels.

Actively at Work

You are considered actively at work if you are:

- Working at the Company's usual place of business, or on an assignment for the purpose of furthering the Company's business;
- Performing the material and substantial duties of your regular occupation on a full-time basis; and
- Not receiving severance or salary continuation pay.

You are considered actively at work during a scheduled vacation or a holiday, during an approved leave under FMLA or on an approved personal leave of absence of less than 31 days.

Acupuncturist

Means a duly licensed acupuncturist operating within the scope of his or her license.

Acute Treatment Services

A 24-hour medically supervised addiction treatment that provides evaluation and withdrawal management and may include biopsychosocial assessment, individual and group counseling, psychoeducational groups, and discharge planning.

Administrator Hospital

See definition of hospital.

Administrator Program

Means programs for which a Hospital has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide service to you at the time services are rendered to you. These programs are limited to a Partial Hospitalization Treatment Program or Coordinated Home Care Program.

Administrator Provider

A ***provider*** who has a written agreement with the ***Claim Administrator*** (or another Blue Cross and Blue Shield Plan or Blue Cross Plan) to provide services to you at the time services are rendered to you.

Advanced Practice Nurse

A certified clinical nurse specialist, certified nurse-midwife, certified nurse practitioner or certified registered nurse anesthetist.

Ambulance Services

Local transportation 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 facility;
- To a hospital; or
- From one skilled nursing facility or hospital to your home.

If there are no facilities in the local area equipped to provide the care needed, ambulance transportation then means the transportation to the closest facility that can provide the necessary care. Ambulance Transportation provided for the convenience of you, your family/caregivers or Physician, or the transferring facility, is not considered Medically Necessary and is not covered under this health care plan.

Ambulance Transportation

Means local transportation in specially equipped certified ground and air ambulance options from your home, scene of accident or medical emergency to a Hospital, between Hospital and Hospital, between Hospital and Skilled Nursing Facility or from a Skilled Nursing Facility or Hospital to your home. If there are no facilities in the local area equipped to provide the care needed, Ambulance Transportation then means the transportation to the closest facility that can provide the necessary service. Ambulance Transportation provided for the convenience of you, your family/caregivers or Physician, or the transferring facility, is not considered Medically Necessary and is not covered under this health care plan.

Ambulance Transportation Eligible Charge

Means

i) for ambulance providers that bill for Ambulance Transportation services through a Participating Hospital the Ambulance Transportation Eligible Charge is the applicable ADP, and

ii) ii) for all other ambulance providers, the Ambulance Transportation Eligible Charge is such provider's Billed Charge.

Ambulatory Surgical Facility

Means a facility (other than a Hospital) whose primary function is the provision of surgical procedures on an ambulatory basis, and which is duly licensed by the appropriate state and local authority to provide such services.

An "Administrator Ambulatory Surgical Facility" means an Ambulatory Surgical Facility which has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered to you.

A "Non-Administrator Ambulatory Surgical Facility" means an Ambulatory Surgical Facility which does not meet the definition of an Administrator Ambulatory Surgical Facility.

Anesthesia Services

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.

Approved Clinical Trial

Means a phase I, phase II, phase III or phase IV clinical trial that is conducted in relation to the preventive, detection or treatment of cancer or other life-threatening disease or condition and is one of the following:

(i) A federally funded or approved trial,

(ii) A clinical trial conducted under an FDA experimental/investigational new drug application, or

(iii) A drug that is exempt from the requirement of an FDA experimental/investigational new drug application.

Assistant Surgeon

A ***physician***, ***dentist*** or ***podiatrist*** who assists the operating surgeon in performing covered ***surgery***. The Plan only pays benefits for services performed by an ***assistant surgeon*** if a ***hospital*** intern or resident is not available for such assistance.

Audiologist

Means a duly licensed Audiologist operating within the scope of his or her license.

- A "Participating Audiologist" means an Audiologist who has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time Covered Services are rendered.
- A "Non-Participating Audiologist" means an Audiologist who does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide Covered Services to you at the time Covered Services are rendered.

Autism Spectrum Disorders

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.

Average Discount Percentage

A percentage discount determined by the ***Claim Administrator*** that will be applied to a ***provider's eligible charge*** for ***covered services*** rendered to you by ***hospitals*** and certain other health care facilities for purposes of calculating ***coinsurance*** amounts, deductibles, out-of-pocket maximums and/or any benefit maximums. The Average Discount Percentage will often vary from ***claim***-to-***claim***. The Average Discount Percentage applicable to a particular ***claim*** for ***covered services*** is the Average Discount Percentage, current on the date the ***covered service*** is rendered that is determined by the ***Claim Administrator*** to be relevant to the particular ***claim***. The Average Discount Percentage reflects the ***Claim Administrator's*** reasonable estimate of average payments, discounts and/or other allowances that will result from its contracts with ***hospitals*** and other facilities under circumstances similar to those involved in the particular ***claim***, reduced by an amount not to exceed 15% of such estimate, to reflect related costs. In determining the Average Discount Percentage applicable to a particular ***claim***, the ***Claim Administrator*** will take into account differences among ***hospitals*** and other facilities, the ***Claim Administrator's*** contracts with ***hospitals*** and other facilities, the nature of the ***covered services*** involved and other relevant factors. The Average Discount Percentage shall not apply to ***eligible***

charges when your benefits under the Health Care Plan are secondary to ***Medicare*** and/or coverage under any other group program.

Behavioral Health Practitioner

Means a Physician or Professional Provider who is duly licensed to render services for Mental Illness or Substance Use Disorders and is operating within the scope of such license.

Behavioral Health Unit

Means 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.

Billed Charges

Means the total gross amounts billed by Providers to the Claim Administrator on a Claim, which constitutes the usual retail price that the Provider utilizes to bill patients or any other party that may be responsible for payment of the services rendered without regard to any payor, discount or reimbursement arrangement that may be applicable to any particular patient. This list of retail prices is also sometimes described in the health care industry as a "charge master."

Biomarker Testing

Means the analysis of tissue, blood, or fluid biospecimen for the presence of a biomarker, including, but not limited to singly-analyte tests, multi-plex panel tests, and partial or whole genome sequencing.

Care Coordinator

Means organized, information-driven patient care activities intended to facilitate the appropriate responses to participant's health care needs cross the continuum of care.

Care Coordinator Fee

Means a fixed amount paid by a Blue Cross and/or Blue Shield plan to Providers.

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.

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.

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.

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.

Chemotherapy

The treatment of a malignant condition by pharmaceutical and/or biological anti-neoplastic drugs.

Chiropractor

A duly licensed chiropractor.

Civil Union

Means a legal relationship between two persons of either the same or opposite sex, established pursuant to or as otherwise recognized by the Illinois Religious Freedom Protection and Civil Union Act.

Claim

Notification in a form acceptable to the ***Claim Administrator*** that a service has been rendered or furnished to you. This notification must include full details of the service received, including your name, age, sex, identification number, the name and address of the ***provider***, an itemized statement of the service rendered or furnished (including appropriate codes), the date of service, the diagnosis (including appropriate codes), the ***claim charge***, and any other information which the ***Claim Administrator*** may request in connection with services rendered to you. In the case of a ***claim*** that is not for benefits or payment for services rendered, a ***claim*** is a notification in writing, or in another form acceptable to the ***Plan Administrator*** that details the nature of the right you are asserting or action you are seeking.

Claim Administrator

Blue Cross and Blue Shield of Illinois.

Claim Charge

Means the amount which appears on a ***claim*** as the ***provider's*** charge for service rendered to you, without adjustment or reduction and regardless of any separate financial arrangement between the ***Claim Administrator*** and a particular ***provider***.

Claim Payment

Means the benefit payment calculated by the Claim Administrator, after submission of a Claim, in accordance with the benefits described in this benefit booklet. All Claim Payments will be calculated on the basis of the Eligible Charge for Covered Services rendered to you, regardless of any separate financial arrangement between the Claim Administrator and a particular Provider. (See provisions regarding "The Claim Administrator's Separate Financial Arrangements with Providers" in the GENERAL PROVISIONS section of this benefit booklet.)

Clinical Laboratory

A clinical laboratory that complies with the licensing and certification requirements under the Clinical Laboratory Improvement Amendments of 1988, the ***Medicare*** and Medicaid programs and any applicable state and local statutes and regulations.

- A "Participating Clinical Laboratory" means a Clinical Laboratory which has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.
- A "Non-Participating Clinical Laboratory" means a Clinical Laboratory which does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan provide services to you at the time services are rendered.

Clinical Professional Counselor

A duly licensed clinical professional counselor operating within the scope of his or her license.

- A "Participating Clinical Professional Counselor" means a Clinical Professional Counselor who has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.
- A "Non-Participating Clinical Professional Counselor" means a Clinical Professional Counselor who does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

Clinical Social Worker

A duly licensed clinical social worker operating within the scope of his or her license.

- A "Participating Clinical Social Worker" means a Clinical Social Worker who has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

- A "Non-Participating Clinical Social Worker" means a Clinical Social Worker who does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

Clinical Stabilization Services

24-hour treatment, usually following acute treatment services for Substance Use Disorder, which may include intensive education and counseling regarding the nature of addiction and its consequences, relapse prevention, outreach to families and significant others, and aftercare planning for individuals beginning to engage in recovery from addiction.

Clinician

Means a person operating within the scope of his/her license, registration or certification in the clinical practice or medicine, psychiatry, psychology, or behavior analysis.

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 Program.

Coinsurance

A percentage of an eligible expense that you are required to pay towards a ***covered service***.

Company

The term "Company" collectively refers to all subsidiaries of MMS USA Holdings, Inc. that have approved participation in the Publicis Connections Health and Group Benefit Programs. Participating Employers are listed in Schedule A to the Administrative Information Summary Plan Description.

Complications of Pregnancy

All physical effects suffered as a result of pregnancy which would not be considered the effect of normal pregnancy.

Congenital or Genetic Disorder

Means a disorder that includes, but is not limited to, hereditary disorders. Congenital or Genetic Disorders may also include, but is not limited to, Autism or an Autism Spectrum Disorder, cerebral palsy, and other disorders resulting from early childhood illness, trauma, or injury.

Contracted Provider

Means a Participating Provider and a Participating Professional Provider, collectively.

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 services***. It also does not cover services for activities of daily living (personal hygiene, cleaning, cooking, etc.).

Copayment

A specified dollar amount that you are required to pay towards a ***covered service***.

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.

Coverage Date

The date on which your coverage under the Health Care Plan begins.

Covered Service

A service and supply specified in this SPD for which benefits will be provided.

Creditable Coverage

Coverage you had under any of the following:

- A group health plan.
- Health insurance coverage for medical care under any hospital or medical service policy plan, hospital or medical service plan contract, or HMO contract offered by a health insurance issuer.
- ***Medicare*** (Parts A or B of Title XVIII of the Social Security Act).
- Medicaid (Title XIX of the Social Security Act).
- Medical care for members and certain former members of the uniformed services and their dependents.
- A medical care program of the Indian Health Service or of a tribal organization.
- A State health benefits risk pool.
- A health plan offered under the Federal Employees Health Benefits Program.
- A public health plan established or maintained by a State or any political subdivision of a State, the U.S. government, or a foreign country.
- A health plan under Section 5(e) of the Peace Corps Act.
- State Children's Health Insurance Program (Title XXI of the Social Security Act).

Custodial Care Services

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 services" also means providing care on a continuous ***inpatient*** or ***outpatient*** basis without any clinical improvement by you.

Deductible

The amount of expense that you must incur in Covered Services before benefits are provided.

Dentist

This means a legally qualified dentist.

Diagnostic Services

Tests rendered to diagnose a symptom or evaluate the 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.

Domestic Partner

Your same or opposite sex domestic partner includes any individual that you have been residing within the same residence for at least six months. You need to complete the Affidavit for Certification of Domestic Partnership (available in the Forms Library on the Publicis Connections website) before coverage begins.

You must meet all of the following to be eligible for coverage of a ***domestic partner***:

- You have shared a monogamous, committed relationship with one another that has existed for at least six months and is expected to last indefinitely;
- You are jointly responsible for each other's welfare and financial obligations;
- You share your principal place of residence;
- You are both at least 18 years old and mentally competent to consent to the contract;
- Neither of you are married to anyone else; and
- You are not related to each other in a way that would prevent a marriage from being recognized under the laws of the state in which you live.

You also may be required to prove your interdependence (if requested). You can do so by providing two of the following documents:

- Common ownership of real property;

- Common ownership of a motor vehicle;
- Driver's license that lists a common address;
- Proof of joint bank accounts or credit accounts;
- Proof of designation as the primary beneficiary for life insurance or primary beneficiary designation under a partner's will;
- Assignment of a property power of attorney or health care power of attorney.

Domestic partnerships are not recognized by the federal government for tax purposes.

DRUG LIST

A list of pharmaceutical products which is available to covered persons, physicians or other health care providers for purposes of providing information about the coverage and tier status of individual pharmaceutical products.

DURABLE MEDICAL EQUIPMENT PROVIDER

A duly licensed durable medical equipment provider, when operating within the scope of such license.

A "Participating Durable Medical Equipment Provider" means a Durable Medical Equipment Provider who has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A "Non - Participating Durable Medical Equipment Provider" means a Durable Medical Equipment Provider who does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

EARLY ACQUIRED DISORDER

Disorder resulting from illness, trauma, injury, or some other event or condition suffered by a child prior to that child developing functional life skills such as, but not limited to, walking, talking or self - help skills. Early Acquired Disorder may include, but is not limited to, Autism or an Autism Spectrum Disorder and cerebral palsy.

Eligible Charge

in the case of a Provider, other than a Professional Provider, which has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide care to participants in the benefit program or is designated as a Participating Provider by any Blue Cross and/or Blue Shield Plan at the time Covered Services are rendered, such Provider's Claim Charge for Covered Services and (b) in the case of a Provider, other than a Professional Provider, which does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide care to participants in the benefit program, or is not designated as a Participating Provider by any Blue Cross and/or Blue Shield Plan the following amount:

(i) the lesser of (unless otherwise required by applicable law or arrangement with the Non-Participating Provider) (a) the Provider's Billed Charges, and (b) an amount determined by the Claim Administrator to be approximately 300% of the base Medicare

reimbursement rate, excluding any Medicare adjustment(s) which is/are based on information on the Claim; or

(ii) if there is no base Medicare reimbursement rate available for a particular Covered Service, or if the base Medicare reimbursement amount cannot otherwise be determined under subsection (i) above based upon the information submitted on the Claim, the lesser of (unless otherwise required by applicable law or arrangement with the Non-Participating Provider) (a) the Provider's Billed Charges and (b) an amount determined by the Claim Administrator to be 300% of the Maximum Allowance that would apply if the services were rendered by a Participating Professional Provider on the date of service; or

(iii) if the base Medicare reimbursement amount and the Maximum Allowance cannot be determined under subsections (i) or (ii) above, based upon the information submitted on the Claim, then the amount will be 300% of the Provider's Billed Charges (unless otherwise required by applicable law or arrangement with the Non-Participating Provider), provided, however, that the Claim Administrator may limit such amount to the lowest contracted rate that the Claim Administrator has with a Participating Provider for the same or similar services based upon the type of provider and the information submitted on the Claim, as of January 1 of the same year that the Covered Services are rendered to you.

In addition to the foregoing, the Eligible Charge will be subject in all respects to the Claim Administrator's Claim Payment rules, edit and methodologies regardless of the Provider 's status as a Participating Provider or Non-Participating Provider. (See provisions of this benefit booklet regarding “The Claim Administrator's Separate Financial Arrangements with Providers.”)

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 (unless otherwise required by applicable law or arrangement with the Non-Participating Provider).

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 from the information submitted on the Claim, the Eligible Charge for Non-Participating or Non-Administrator Providers will be 50% of the Non-Participating Provider's standard billed charge for such Covered Service (unless otherwise required by applicable law or arrangement with the Non-Participating Provider). (See provisions of this benefit booklet regarding “The Claim Administrator's Separate Financial Arrangements with Providers.”)

The Claim Administrator will utilize the same Claim processing rules and/or edits that it utilizes in processing Participating Provider Claims for processing Claims submitted by Non-Participating or Non-Administrator Providers which may also alter the Eligible Charge for a particular service. In the event the Claim Administrator does not have any Claim edits or rules, the Claim Administrator may utilize the Medicare claim rules or edits that are used by Medicare in processing the Claims. The Eligible Charge will not include any additional payments that may be permitted under the Medicare laws or regulations which are not directly attributable to a

specific Claim, including, but not limited to, disproportionate share payments and graduate medical education payments.

Any change to the Medicare reimbursement amount will be implemented by the Claim Administrator within 145 days after the effective date that such change is implemented by the Centers for Medicaid and Medicare Services, or its successor.

Eligible Person

An employee of the ***Company*** who meets the eligibility requirements for this health and/or dental coverage, as described in the Eligibility section of this SPD.

Emergency Accident Care

The initial ***outpatient*** treatment of accidental medical injuries including any related ***diagnostic services***. The initial ***outpatient*** treatment does not include ***surgical*** procedures, including but not limited to, stitching, gluing and casting.

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 Mental Illness or Substance use Disorder Admission

An admission for the treatment of Mental Illness or Substance Use Disorders as a result of the sudden and unexpected onset of a Mental Illness or Substance Use Disorder condition such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect that in the absence of immediate medical treatment would likely result in serious and permanent medical consequences to oneself or others.

Employer

The company with which you are employed.

Enrollment Date

The first day of coverage under the Program or, if you are subject to a waiting period prior to the effective date of your coverage, the first day of the waiting period (typically, the date employment begins).

Experimental/Investigational or Experimental/Investigational Services and Supplies

The use of any treatment, procedure, facility, equipment, drug, device, or supply not accepted as Standard Medical Treatment for the condition being treated or, if any of such items required federal or other governmental agency approval, such approval was not granted at the time services were provided. Approval by a federal agency means that the treatment, procedure, facility, equipment, drug, device, or supply has been approved for the condition being treated and, in the case of a drug, in the dosage used on the patient. As used herein, medical treatment includes medical, surgical, mental health treatment, Substance Use Disorder Treatment, or dental treatment.

Standard Medical Treatment means the services or supplies that are in general use in the medical community in the United States, and:

- have been demonstrated in peer reviewed literature to have scientifically established medical value for curing or alleviating the condition being treated;
- are appropriate for the Hospital or Facility Other Provider in which they were performed; and
- the Physician or Professional Other Provider has had the appropriate training and experience to provide the treatment or procedure.

The medical staff of the Claim Administrator shall determine whether any treatment, procedure, facility, equipment, drug, device, or supply is Experimental/Investigational, and will consider the guidelines and practices of Medicare, Medicaid, or other government-fixed programs in making its determination.

Although a Physician or Professional Provider may have prescribed treatment, and the services or supplies may have been provided as the treatment of last resort. The Claim Administrator still may determine such services or supplies to be Experimental/Investigational with this definition. Treatment provided as part of a clinic trial or research study is Experimental/Investigational. Approval by a government or regulatory agency will be taken into consideration in assessing Experimental/Investigational status of a drug, device, biological product, supply and equipment for medical treatment or procedure but will not be determinative.

Family Coverage

Means coverage for you and your eligible dependents under the Health Care Plan.

Formulary Brand

A selected brand name drug chosen for its ability to meet patient needs at a lower cost. If a ***generic*** drug is not available, there may be more than one formulary brand drug available to treat a condition. An updated list of formulary drugs is available at www.bcbsil.com.

You pay more when you purchase brand name drugs that are not on the prescription drug formulary list.

Generic

Generic drugs are less expensive for you and for the ***Company***, so 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*** drug – unless your ***provider*** specifically indicates that a non-

formulary brand be used. (This is called "dispense as written.") Of course, if you want a non-***formulary brand*** prescription, you can request it, but you will have to pay the non-***formulary brand copayment***.

A generic drug includes the same active ingredients as its counterpart non-***formulary brand*** drug. Most health care professionals believe the generic drugs are as effective and safe as non-***formulary brand*** drugs. However, the decision about whether you should use a generic or ***formulary brand*** drug rests with you and your ***physician***.

Habilitative Services

Occupational Therapy, Physical Therapy, Speech Therapy, and other health care services that help an eligible person keep, learn, or improve skills and functioning for daily living, as prescribed by a Physician pursuant to a treatment plan. Examples include therapy for a child who isn't walking or talking at the expected age and includes therapy to enhance the ability of a child to function with a Congenital, Genetic, or Early Acquired Disorder. These services may include Physical Therapy and Occupational Therapy, speech-language pathology, and other services for an eligible person with disabilities in a variety of Inpatient and/or Outpatient settings, with coverage as described in this benefit booklet.

Home Infusion Therapy Provider

A duly licensed home infusion therapy provider, when operating within the scope of such license.

- A "Participating Home Infusion Therapy Provider" means a Home Infusion Therapy Provider who has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.
- A "Non-Participating Home Infusion Therapy Provider" means a Home Infusion Therapy Provider who does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

Hospice Care Program

A centrally administered program designed to provide for the physical, psychological and spiritual care for a dying person and his or her family. 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 is received in the home, a ***skilled nursing facility***, or in a special hospice care unit.

Hospice Care Program Provider

An organization duly licensed to provide ***hospice care program*** services, when operating within the scope of such license.

A "Participating Hospice Care Program Provider" means a Hospice Care Program Provider that either: (i) has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield to provide services to participants in this benefits program, or; (ii) a Hospice Care Program Provider which has been designated by a Blue Cross and/or Blue Shield Plan as a Participating Provider Option program.

A "Non-Participating Hospice Care Program Provider" means a Hospice Care Program Provider that either: (i) does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield to provide services to participants in this benefits program the, or; (ii) a Hospice Care Program Provider which has not been designated by a Blue Cross and/or Blue Shield Plan as a Participating Provider Option program.

Hospice Care Program Service

A centrally administered program designed to provide for the physical, psychological, and spiritual care for dying persons and their families. The goal of hospice care is to allow the dying process to proceed with a minimum of patient discomfort while maintaining dignity and a quality of life. Hospice Care Program Service is available in the home, Skilled Nursing Facility, or special hospice care unit.

Hospital

A duly licensed institution accredited as a hospital by the Joint Commission on Accreditation of Healthcare Organizations. It's designed to care for the sick and provide services under the care of a ***physician*** – including the regular provision of bedside nursing by registered nurses. It does not include health resorts, rest homes, nursing homes, ***skilled nursing facilities***, convalescent homes, drug rehabilitation centers, custodial homes for the aged or similar institutions.

An "***Administrator Hospital***" means a ***hospital*** which has a written agreement with the ***Claim Administrator*** or another Blue Cross and Blue Shield Plan or Blue Cross Plan to provide services to you at the time services are rendered to you.

A "***Non-Administrator Hospital***" means a ***hospital*** that does not meet the definition of an ***administrator hospital***.

A "***Participating Hospital***" means an ***administrator hospital*** that has an agreement with the ***Claim Administrator*** or another Blue Cross and Blue Shield Plan or Blue Cross Plan to provide Hospital services to participants in the Participating Provider Option program.

A "***Non-Participating Hospital***" means an ***administrator hospital*** that does not meet the definition of a ***participating hospital***.

Individual Coverage

Coverage under the Program for yourself but not your ***spouse***, ***domestic partner***, and/or dependents.

Infertility

The inability to conceive a child after one year of unprotected sexual intercourse, or the inability to sustain a successful pregnancy.

Infusion Therapy

The administration of medication through a needle or catheter. It is prescribed when a patient's condition is so severe that it cannot be treated effectively by oral medications. Typically, "Infusion Therapy" means that a drug is administered intravenously, but the term also may refer to situations where drugs are provided through other non-oral routes, such as intramuscular injections and epidural routes (into the membranes surrounding the spinal cord). Infusion

Therapy, in most cases, requires health care professional services for the safe and effective administration of the medication.

Injectable Medications

Many common injectable medications are available through selected pharmacies. The most common injectable medications include:

- Imitrex (dispensing limits apply);
- Lovanox;
- Fragmin;
- Glucago;
- Insulin; and
- Bee-sting kits.

Please visit the Blue Cross Blue Shield website at www.bcbsil.com to confirm that your injectable medication is covered. The site also contains additional information regarding ***covered services***.

Inpatient

You are a registered bed patient and are treated as such in a health care facility.

Investigational or Experimental Services and Supplies

Procedures, drugs, devices, services and/or supplies which:

- 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
- Are awaiting endorsement by the appropriate National Medical Specialty College or federal government agency for general use by the medical community at the time they're rendered to you; and/or
- Specifically with regard to drugs, combination of drugs, and/or devices, are not finally approved by the Federal Drug Administration at the time of use or administered to you.

Inpatient

You are a registered bed patient and are treated as such in a health care facility.

Intensive Outpatient Program

A freestanding or Hospital-based program that provides services for at least 3 hours per day, 2 or more days per week, to treat Mental Illness or Substance Use Disorder or specializes in the treatment of co-occurring Mental Illness and Substance Use Disorder. Requirements: the Claims Administrator requires that any Mental Illness and/or Substance Use Disorder Intensive Outpatient Program 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 the current credentialing policy, and otherwise meets all other credentialing requirements set forth in such policy.

Intensive Outpatient Program services may be available with less intensity if you are recovering from severe and/or chronic Mental Illness and/or Substance Use Disorder conditions. If you are recovering from severe and/or chronic Mental Illness and/or Substance Use Disorder conditions, services may include psychotherapy, pharmacotherapy, and other interventions aimed at supporting recovery such as the development of recovery plans and advance directives, strategies for identifying and managing early warning signs of relapse, development of self-management skills, and the provision of peer support services.

Intensive Outpatient Programs may be used as an initial point of entry into care, as a step up from routine Outpatient services, or as a step down from acute Inpatient, residential care or a Partial Hospitalization Treatment Program.

Legend Drug

Legend drug means any drug defined by section 503(b) of the Federal Food, Drug and Cosmetic Act under which definition its label is required to bear the statement "Rx only."

Life-Threatening Disease or Condition

For the purposes of a clinical trial, any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

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.

Long-Term or Maintenance Medications

A drug that you take on a regular basis to treat an ongoing chronic health condition. The following conditions are examples of those that require long-term medications:

- High blood pressure;
- Ulcers;
- Arthritis;
- Allergies and asthma;
- Heart or thyroid conditions; and
- Diabetes.

Maintenance Care

Those services administered to you to maintain a level of function at which no demonstrable and/or measurable improvement of condition will occur.

Maintenance Occupational, Physical Therapy, or Speech Therapy

Therapy administered to you to maintain a level of function at which no demonstrable and measurable improvement of a condition will occur.

Marriage And Family Therapist ("LMFT")

A duly licensed marriage and family therapist operating within the scope of his or her license.

- A “Participating Marriage and Family Therapist” means a Marriage and Family Therapist who has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.
- A “Non-Participating Marriage and Family Therapist” means a Marriage and Family Therapist who does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

Maternity Service

The services rendered for normal pregnancy. A normal pregnancy means an intrauterine pregnancy which, through vaginal delivery, results in an infant, who is not premature or preterm. Premature or preterm means an infant born with a low birth weight, 5.5 pounds or less, or an infant born at 37 weeks or less.

Maximum Allowance

Maximum allowance is: (a) the amount which Participating Professional Providers have agreed to accept as payment in full for a particular Covered Service. All benefit payments for Covered Services rendered by Participating Professional Providers will be based on the Schedule of Maximum Allowances which these Providers have agreed to accept as payment in full.
(b) For Non-Participating
Professional Providers, the Maximum Allowance will be the lesser of (unless otherwise required by applicable law or arrangement with the Non-Participating Providers):

(i) the Provider's billed charges, or;

(ii) the Claim Administrator non-contracting Maximum Allowance. Except as otherwise provided in this section, the non-contracting Maximum Allowance is developed from base Medicare reimbursements and represents approximately 300% 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.

When a Medicare reimbursement rate is not available for a Covered Service or is unable to be determined from the information submitted on the Claim, the Maximum Allowance for Non-Participating Professional Providers will be 100% of the Claim Administrator's rate for such Covered Service according to its current Schedule of Maximum Allowance. If there is no rate according to the Schedule of Maximum Allowance, then the Maximum Allowance will be 25% of Billed Charges.

The Claim Administrator will utilize the same Claim processing rules and/or edits that it utilizes in processing Participating Professional Provider Claims for processing Claims submitted by Non-Participating Professional Providers which may also alter the Maximum Allowance for a particular service. In the event the Claim Administrator does not have any Claim edits or rules, the Claim Administrator may utilize the Medicare claim rules or edits that are used by Medicare in processing the Claims. The Maximum Allowance will not include any additional payments that may be permitted under the Medicare laws or regulations which are not directly attributable to a specific Claim, including, but not limited to, disproportionate share payments and graduate medical education payments.

Any change to the Medicare reimbursement amount will be implemented by the Claim Administrator within 145 days after the effective date that such change is implemented by the Centers for Medicaid and Medicare Services, or its successor.

Medical Care

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

When care is ***medically necessary***, a specific medical, health care or ***hospital*** service is required based on the reasonable medical judgment of the ***Claim Administrator*** to treat or manage a medical symptom or condition. In addition, the service or care is provided in the most efficient, safe and economical manner.

Hospitalization is not considered ***medically necessary*** when, in the reasonable medical judgment of the ***Claim Administrator***, the medical services provided do not require an acute ***hospital inpatient*** setting, but could be provided in a ***physician's*** office, the ***outpatient*** department of a ***hospital***, or some other setting without adversely affecting the patient's condition. The following are examples of hospitalization and other health care services and supplies that are not considered ***medically necessary***:

- Hospital admissions for or consisting primarily of observation and/or evaluation that can safely and adequately be provided in some other setting (i.e., a physician's office or hospital outpatient department);
- Hospital admissions that are primarily diagnostic in nature (i.e., x-rays, laboratory and pathological services, and machine diagnostic tests), and that can be safely and adequately provided in some other setting (i.e., the hospital outpatient department or a physician's office);
- Continued inpatient hospital care (when a 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 primarily for custodial care services, convalescent care, rest cures or domiciliary care.
- Hospitalization or admission to a skilled nursing facility for the patient's or physician's convenience, or because care in the home is not available or is unsuitable.

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

The Plan does not pay benefits for services that are not in the reasonable judgment of the ***claim*** Administrator ***medically necessary***. The ***Claim Administrator*** makes the decision as to whether hospitalization or other health care services or supplies are ***medically necessary*** and eligible for Plan benefits. In most instances the ***Claim Administrator*** makes this decision after you are hospitalized, you receive care, or after a ***claim*** is submitted.

Please Note: Just because your ***physician*** may prescribe, order, recommend, approve or view hospitalization or other health care services and supplies as ***medically necessary***, it does not mean that the hospitalization, service, or supply is ***medically necessary*** For purposes of payment under this Plan. As a result, the ***Claim Administrator*** may not pay the cost of the hospitalization, service or supply.

If your ***claim*** for benefits is denied on the basis that the service or supplies are not ***medically necessary*** and you disagree with the ***Claim Administrator***'s decision, you may appeal that decision. See the appeals section for details.

Medicare

The program established by Title XVIII of the Social Security Act (42 U.S.C. §1395 et seq.).

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 or 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 use disorder rehabilitation treatment*** benefits including ***preauthorization, emergency mental illness or substance use disorder admission review*** and length of stay/service review for ***inpatient hospital*** admissions for the treatment of ***mental illness*** and ***substance use disorders***.

Mental Illness

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

"Serious Mental Illness" includes 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

Naprapath

A duly licensed Naprapath operating within the scope of such license.

- A "Participating Naprapath" means a Naprapath who has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.
- A "Non-Participating Naprapath" means a Naprapath who does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.Naprapathic Services

The performance of naprapathic practice by a ***naprapath*** which may legally be rendered by them.

Negotiated Rate

This is the maximum charge a network ***provider*** has agreed to make as to any service or supply for the purpose of the benefits under this Plan.

Network Benefits

In-Network Benefits – You receive in-network benefits when a participating provider renders eligible services.

Out-of-Network Benefits – You receive out-of-network benefits when a non-participating provider renders eligible services.

Non-Administrator Hospital

See definition of hospital.

Non-Administrator Provider

These ***providers*** do not meet the definition of an ***administrator provider*** unless specified in the definition of a particular ***provider***. When you receive ***covered services*** from a ***non-administrator provider***, benefits will be provided at 50% of the ***eligible expense*** after you have met your deductible and your ***inpatient hospital*** admission deductible.

Non-Participating Hospital

See definition of hospital.

Non-Participating Pharmacy

These pharmacies do not sign an agreement with the ***Claim Administrator*** and do not accept the ***maximum allowance*** as payment in full. As a result, you are responsible for paying the full cost of these services. If you fill your prescription at a ***non-participating pharmacy***, the Plan pays

benefits at the 75% ***coinsurance*** level, less your ***copayment*** requirement. You must submit a ***claim*** form for the Plan to pay benefits.

Non-Participating Providers

These ***providers*** do not sign an agreement with the ***Claim Administrator*** and do not accept the ***maximum allowance*** as payment in full. As a result, you are responsible to pay these ***providers*** for the difference between the Plan's benefit payment and the ***provider's*** charge to you for the ***eligible expense***. ***Non-participating providers*** may include:

- Physicians;
- Podiatrists;
- Psychologists;
- Dentists;
- Certified nurse-midwives;
- Chiropractors;
- Clinical social workers;
- Clinical professional counselors;
- Clinical laboratories;
- CRNAs;
- Hospitals or other medical facilities;
- Physical therapists;
- Occupational therapists;
- Speech therapists; and
- Other professional providers.

If you want to know the ***maximum allowance*** for a particular procedure, or if you want to know if a particular ***provider*** participates in the network, contact your ***provider*** or the ***Claim Administrator***.

Occupational Therapist

A duly licensed occupational therapist operating within the scope of his or her license.

Occupational Therapy

Constructive therapeutic activity that's designed and adapted to promote the restoration of useful physical function. Occupational therapy does not include educational training or services designed and adapted to develop a physical function.

Optometrist

A duly licensed optometrist operating within the scope of his or her license.

- A "Participating Optometrist" means an Optometrist who has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

- A “Non-Participating Optometrist” means an Optometrist who does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

Orthotic Provider

A duly licensed orthotic provider operating within the scope of his or her license.

- A “Participating Orthotic Provider” means an Orthotic Provider who has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.
- A “Non-Participating Orthotic Provider” means an Orthotic Provider who does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

Outpatient

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

A Claim Administrator approved planned program of a Hospital or Substance Use Disorder Treatment Facility for the treatment of Mental Illness or Substance Use Disorder Treatment in which patients spend days or nights. This behavioral healthcare is typically 5 to 8 hours per day, 5 days per week (not less than 20 hours of treatment services per week). The program is staffed similarly to the day shift of an Inpatient unit, i.e., medically supervised by a Physician and nurse. The program shall ensure a psychiatrist sees the patient face to face at least once a week and is otherwise available, in person or by telephone, to provide assistance and direction to the program as needed. Participants at this level of care do not require 24-hour supervision and are not considered a resident at the program. Requirements: The Claim Administrator requires that any Mental Illness and/or Substance Use Disorder Partial Hospitalization Treatment Program must be licensed in the state where it is located or accredited by a national organization that is recognized by the Claim Administrator as set forth in its current credentialing policy, and otherwise meets all other credentialing requirements set forth in such policy.

Participating Pharmacies

A ***pharmacy*** that has a written agreement with the ***Claim Administrator*** (or another Blue Cross and Blue Shield Plan) to provide services to PPO participants. These pharmacies participate in a network, which includes national and regional chain stores and many independent pharmacies. To find out if your ***pharmacy*** participates in the network, go to the online directory at www.bcbsil.com, or call the ***Claim Administrator***.

Participating Providers

A ***provider*** who has a written agreement with the ***Claim Administrator*** (or another Blue Cross and Blue Shield Plan) to provide services to PPO participants, or an administrator facility which the ***Claim Administrator*** designates as a ***participating provider***. A ***provider*** can include any health care facility (for example a ***hospital*** or ***skilled nursing facility***) or person (for example a ***dentist*** or ***physician***) or entity that’s duly licensed to render eligible services to you or a covered dependent. Here are some examples of ***participating providers***:

- Physicians;
- Podiatrists;
- Psychologists;
- Certified nurse-midwives;
- Chiropractors;
- Clinical social workers;
- Clinical professional counselors;
- Clinical laboratories;
- CRNAs;
- Hospitals and other medical facilities;
- Physical therapists;
- Occupational therapists; and
- Speech therapists.

Participating providers agree not to bill you for expenses in excess of the ***maximum allowance***. As a result, you are responsible only for the difference between the Plan's payment and the ***maximum allowance*** for the particular ***eligible expense*** (i.e., your deductible, ***copayment***, or ***coinsurance*** amount).

Participating Provider Option

A program of health care benefits designed to provide you with economic incentives for using designated Providers of health care services.

Pharmacy

A state and federally licensed establishment where the practice of pharmacy occurs, that is physically separate and apart from any Provider's office, and where Legend Drugs and devices are dispensed under Prescriptions to the general public by a pharmacist licensed to dispense suchdrugs and devices under laws of the state in which he/she practices.

Physical Therapy

The treatment of a disease, injury or condition by physical 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*** does not include educational training or services designed and adapted to develop a physical function.

Physician

A person who's legally licensed and qualified to practice medicine or perform ***surgery*** within the scope of his or her profession.

Physician Assistant

A duly licensed physician assistant performing under the direct supervision of a ***physician***, ***dentist*** or ***podiatrist*** and billing under such ***provider***.

Plan Administrator

The person or committee designated from time to time as the fiduciary responsible for overall administration of the Plan. Except as otherwise designated in the Administrative Information Summary Plan Description or by a notice from the ***Company***, the ***Plan Administrator*** may be contacted as follows:

Publicis Re:Sources USA
Publicis Benefits Department
Attn: Plan Administrative Committee
35 W. Wacker Dr., 12th Floor
Chicago, IL 60601
1-800-933-3622

Plan Year

The year starting January 1 and ending December 31.

Podiatrist

A duly licensed podiatrist.

Preauthorization, Preauthorize or Emergency Mental Illness or Substance Use Disorder Admission Review

A submission of a request to the ***mental health unit*** for a determination of ***medically necessary*** care under this SPD.

Private Duty Nursing Service

Skilled nursing services provided on a one-to-one basis by an actively practicing registered nurse (R.N.) or licensed practical nurse (L.P.N.). ***Private duty nursing*** is shift nursing of 8 hours or greater per day and does not include nursing care of less than 8 hours per day. ***Private duty nursing services*** do not include ***custodial care*** services.

Prior Authorization

A requirement that you must obtain authorization from the Claim Administrator before you receive certain types of Covered Services designated by the Claim Administrator.

Prior Authorization or Emergency Mental Illness or Substance Use Disorder Admission Review

A submission of a request to the Behavioral Health Unit for a determination of Medically Necessary care under this benefit booklet.

Private Duty Nursing Service

Skilled Nursing Service provided on a one-to-one basis by an actively practicing registered nurse (R.N.), or licensed practical nurse (L.P.N.). Private Duty Nursing is shift nursing of 8 hours or greater per day and does not include nursing care of less than 8 hours per day. Private Duty Nursing Service does not include Custodial Care Service.

Prosthetic Provider

A duly licensed prosthetic provider operating within the scope of his or her license.

- A “Participating Prosthetic Provider” means a Prosthetic Provider who has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.
- A “Non-Participating Prosthetic Provider” means a Prosthetic Provider who does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

Provider

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 and operating within the scope of his or her license.

- An “Administrator Provider” means a Provider which has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered to you.
- A “Non-Administrator Provider” means a Provider that does not meet the definition of Administrator Provider unless otherwise specified in the definition of a particular Provider.
- A “Participating Provider” means an Administrator Hospital or Professional Provider which has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to participants in the Participating Provider Option program or an Administrator facility which has been designated by the Claim Administrator as a Participating Provider.
- A “Non-Participating Provider” means an Administrator Hospital or Professional Provider which does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to participants in the Participating Provider Option program or a facility which has not been designated by the Claim Administrator as a Participating Provider.
- A “Professional Provider” means a Physician, Dentist, Podiatrist, Psychologist, Chiropractor, Optometrist, or any Provider designated by the Claim Administrator or another Blue Cross and/or Blue Shield Plan.
- A “Participating Prescription Drug Provider” means an independent retail Pharmacy, chain of retail Pharmacies, mail-order Pharmacy or specialty drug Pharmacy which has entered into an agreement to provide pharmaceutical services to participants in the benefit program. A retail Participating Pharmacy may or may not be a select Participating Pharmacy as that term is used in the Vaccinations obtained through Participating Pharmacies section.
- A “Non-Participating Prescription Drug Provider” means a Pharmacy, including but not limited to, an independent retail Pharmacy, chain or retail Pharmacies, home delivery Pharmacy or specialty drug Pharmacy which (i) has not entered into a written agreement with the Claim Administrator or (ii) has not entered into a written with any entity chosen by the Claim Administrator to administer its prescription drug program, for such Pharmacy to provide pharmaceutical services at the time Covered Services to participants in the benefit program at the time Covered Services are rendered.PPO Provider
- A general ***physician*** or specialist who meets Blue Cross Blue Shield’s credentialing standards and accepts negotiated fees as payment-in-full for services rendered. PPO providers are listed in the provider directory. Contact Blue Cross Blue Shield for a provider directory.

Provider Incentive

An additional amount of compensation paid to a health care Provider by a Blue Cross and/or Blue Shield Plan, based on the Provider's compliance with agreed upon procedural and/or outcome measures for a particular population of participants.

Psychologist

A clinical psychologist who is registered with the Illinois Department of Professional Regulation pursuant to the Illinois "Psychologists Registration Act." Or, if he or she practices in a state where statutory licensure exists, the clinical psychologist must hold a valid credential for such practice. If he or she practices in a state where statutory licensure does not exist, such person must meet the qualifications specified in the definition of a clinical psychologist.

A clinical psychologist is one who specializes in the evaluation and treatment of ***mental illness*** and:

- Has a doctoral degree from a regionally accredited University, College or Professional School;
- 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;
- Is a registered clinical psychologist with a graduate degree from a regionally accredited University or College; or
- Has six years of experience or more as a psychologist with at least two years of supervised experience in health services.

Qualified Aba Provider

A Provider operating within the scope of his/her 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-Certified Behavior Analyst (BCBA) or Board-Certified Behavior Analyst-Doctoral (BCBA-D), to supervise and provide treatment planning, with ABA services 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.

(i) For the para-professional/line therapist:

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

(iii) 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

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

Recommended Clinical Review

An optional voluntary review of Provider's recommended medical procedure, treatment, or test, that does not require Prior Authorization, to make sure it meets approved Claim Administrator medical policy guidelines and Medical Necessity requirements.

Registered Dietician

A duly licensed clinical professional counselor operating within the scope of his or her license.

Registered Surgical Assistant

A duly licensed certified surgical assistant, certified surgical technician, surgical assistant certified or registered nurse first assistant operating within the scope of his or her certification.

- A "Participating Registered Surgical Assistant" means a Registered Surgical Assistant who has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.
- A "Non-Participating Registered Surgical Assistant" means a Registered Surgical Assistant who does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

Renal Dialysis Treatment

One unit of service including the equipment, supplies and administrative service which are customarily considered as necessary to perform the dialysis process.

Rescission

A cancellation or discontinuance of coverage that has retroactive effect except to the extent attributable to a failure to timely pay premiums. A "Rescission" does not include other types of coverage cancellations, such as a cancellation of coverage due to a failure to pay timely premiums towards coverage or cancellations attributable to routine eligibility and enrollment updates.

Residential Treatment Center

A facility setting offering therapeutic intervention and special programming in a controlled environment which also offers a degree of security, supervision and structure and is licensed by the appropriate state and local authority to provide such service. It does not include halfway houses, supervised living, group homes, boarding houses or other facilities that provide primarily a supportive environment, even if counseling is provided in such facilities. Patients are medically monitored with 24-hour medical availability and 24-hour onsite nursing service for patients with ***mental illness*** and/or ***substance use disorders***.

Respite Care Service

Those services provided at home or in a facility to temporarily relieve the family or other caregivers (non-professional personnel) that usually provide or are able to provide such services to you.

Retail Health Clinic

A health care clinic located in a retail setting, supermarket or Pharmacy which provides treatment of common illnesses and routine preventive health care services rendered by Certified Nurse Practitioners.

- A "Participating Retail Health Clinic" means a Retail Health Clinic which has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.
- A "Non-Participating Retail Health Clinic" means a Retail Health Clinic which does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

Routine Patient Costs

The cost for all items and services consistent with the coverage provided under this benefit booklet that is typically covered for you if you are not enrolled in a clinical trial. Routine Patient Costs do not include:

(i) The investigational item, device, or service, itself;

(ii) Items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or

(iii) A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

Short-Term Prescription

Short-term medications are for periods of 30 days or less.

Skilled Nursing Facility/Service

An institution or a distinct part of an institution which is primarily engaged in providing comprehensive skilled services and rehabilitative Inpatient care and is duly licensed by the appropriate governmental authority to provide such services and operating within the scope of his or her license.

- An "Administrator Skilled Nursing Facility" means a Skilled Nursing Facility which has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered to you.
- A "Non-Administrator Skilled Nursing Facility" means a Skilled Nursing Facility which does not have an agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan but has been certified in accordance with guidelines established by Medicare.
- An "Uncertified Skilled Nursing Facility" means a Skilled Nursing Facility which does not meet the definition of an Administrator Skilled Nursing Facility and has not been certified in accordance with the guidelines established by Medicare**.**

Skilled Nursing Service

Those services provided by a registered nurse (R.N.) or licensed practical nurse (L.P.N.) which require the clinical skill and professional training of an R.N. or L.P.N. and which cannot reasonably be taught to a person who does not have specialized skill and professional training. Benefits for Skilled Nursing Service will not be provided due to the lack of willing or available non-professional personnel. Skilled Nursing Service does not include Custodial Care Service.

Speech Therapist

A duly licensed speech therapist operating within the scope of his or her license.

Speech Therapy

The treatment for the correction of a speech impairment resulting from disease, including pervasive developmental disorders, trauma, congenital anomalies or previous therapeutic processes and which is designed and adapted to promote the restoration of a useful physical function. ***Speech therapy*** does not include educational training or services designed and adapted to develop a physical function.

Spouse

Your spouse includes the individual to whom you are legally married under federal law. Note that under federal law a "common law spouse" will be recognized as a spouse only if relevant state law recognizes the person as a spouse despite the lack of a formal marriage.

Substance Use Disorder

The uncontrollable or excessive abuse of addictive substances, including:

- Alcohol;
- Morphine;
- Cocaine;
- Heroin;
- Opium;
- Cannabis, and other barbiturates;
- Amphetamines;
- Tranquilizers, and/or Hallucinogens.

Abuse constitutes the resultant physiological and/or psychological dependency that the continued use of such addictive substances requires ***medical care***.

Substance Use Disorder/Rehabilitation Treatment

Means an organized, intensive, structured, rehabilitative treatment program of either a ***hospital*** or ***substance use disorder treatment facility***, which may include, but is not limited to Acute Treatment Services and Clinical Stabilization Services. It does not include programs consisting primarily of counseling by individuals other than a ***physician*** or ***psychologist***, court ordered evaluations, programs which are primarily for diagnostic evaluations, mental disability or learning disabilities, care in lieu of detention or correctional placement or family retreats.

Substance Use Disorder Treatment Facility

A facility (other than a ***hospital***) whose primary function is to treat ***substance use disorder***. It's licensed by the appropriate state and local authority to provide such service. It does not include half-way houses, boarding houses or other facilities that primarily provide a supportive environment – even if counseling is provided in such facilities.

Surgery/Surgical

Any medically recognized, non-***investigational*** surgical procedure – including the use of specialized instrumentation and the correction of fractures or complete dislocations.

Temporomandibular Joint Dysfunction and Related Disorders

Jaw joint conditions, including ***temporomandibular joint disorders*** and craniomandibular disorders. It also includes all other conditions of the joint linking the jaw bone and skull, and the complex of muscles, nerves and other tissues relating to that joint.

Tobacco User

A person who is permitted under state and federal law to legally use Tobacco, with Tobacco use (other than religious or ceremonial use of Tobacco), occurring on average four or more times per week that last occurred within the past six months (or such other meaning required or permitted by applicable law). Tobacco includes, but is not limited to, cigarettes, cigars, pipe tobacco, smokeless tobacco, snuff, etc. For additional information, please call the number on the back of your Identification Card or visit our website at www.bcbsil.com.

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.

Transplant Lodging Eligible Expense

The amount of $50 per person per day reimbursed for lodging expenses related to a covered transplant.

Value Based Program

An out-come based payment arrangement and/or a coordinated care model facilitated with one or more local Providers that is evaluated against cost and quality metrics/factors and is reflected in Provider payment.

Virtual Visit

Virtual Visit… means a service provided for the diagnosis or treatment of non-emergency medical and/or behavioral health illnesses or injuries as described in the VIRTUAL VISITS provision under the SPECIAL CONDITIONS AND PAYMENTS section of this benefit booklet.

Virtual Provider

A Virtual Provider… means a licensed Provider who has a written agreement with the Claims Administrator to provider diagnosis and treatment illness through either i) interactive audio

communication (via telephone or other similar technology) or ii) interactive audio/video examination and communication (via online portal, mobile application or similar technology) to you at the time services are rendered, operating within the scope of such license.

Vitamin D Testing

Vitamin D blood testing that measures the level of vitamin D in a person's blood.

Wellness Care

Medical care or specific screenings that encourage good health through early detection and intervention for medical problems.