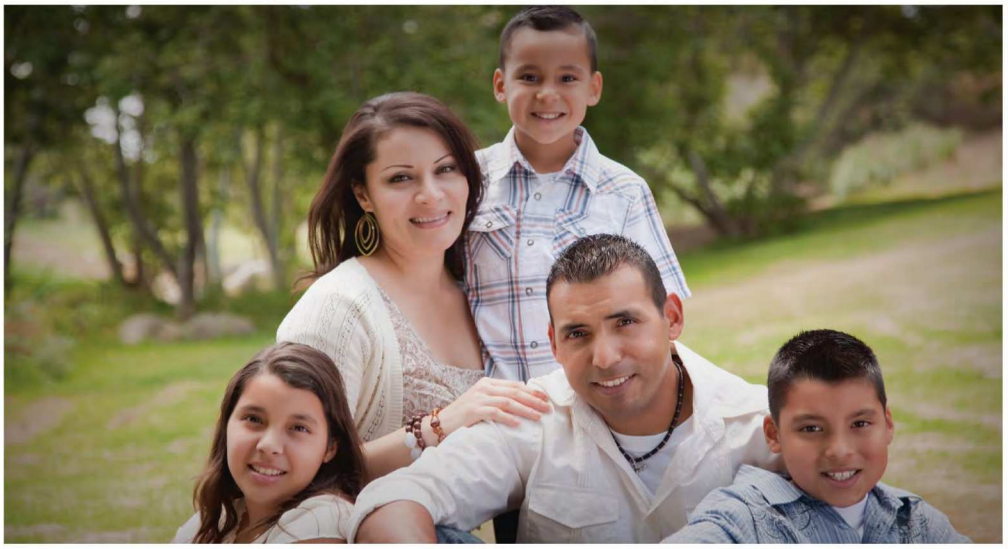
BlueCross BlueShield of Illinois



Experience. Wellness. Everywhere.®

Cicero Public School District #99

2013 Enrollment Guide

The Choice

for Nearly 1 in 3 Americans

Nearly one in every three Americans has a Blue Cross and Blue Shield product.

Experience

Preventive care is essential to maintaining a healthier life, and no one understands this better than Blue Cross and Blue Shield of Illinois (BCBSIL). For more than 70 years, BCBSIL has provided quality health care benefits and services to its members and communities. BCBSIL provides members with programs and support to create customized wellness action plans, make smarter health care choices and help manage their health care.

Your Journey to Wellness

Wellness is defined as the state of being healthy in body and mind, especially as the result of deliberate effort. The choices you make each day can affect your health now and in the future. Deciding on the best approach for a healthier lifestyle can be challenging, but it may be easier than you think.

BCBSIL offers access to convenient online tools and resources to help you plan and manage your health care. BCBSIL health care plans include flexible options with the right combination of benefits, choice of providers and access to a wide variety of educational resources. Whether you are trying to improve your health or reach the next level of wellness, BCBSIL is here to help.

Take time to explore what Blue Cross and Blue Shield of Illinois has to offer. The coverage options, tools and resources can help you on your journey to wellness.

In This Guide

The following pages include a description of the medical plan and other features and services available to you. In some cases, your employer may be offering you more than one medical plan to choose from. Think carefully about how you and your family will use these benefits. Before you make a decision, consider the services that are covered, provider network, potential out-of-pocket costs and other options.

Blue Cross and Blue Shield of Illinois is a leader in health care benefits.

Use the Health Plan Cost Estimator tool to help you see how a medical plan fits your budget and your lifestyle. Go to *www.bcbsil.com/member* and click the Health Plan Decision Tools link.

If you have questions, your employer can provide additional information or direct you to other resources for assistance.

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The PPO Plan

With the PPO plan, you can choose any doctor whenever you need care.

The PPO plan offers a wide range of benefits and the flexibility to choose any doctor or hospital when you need care. The plan includes an annual deductible that you must satisfy before your benefits begin. Qualified medical expenses are applied toward your deductible.

PPO Network

Access to the large network of contracting providers is one of the many reasons to select the PPO plan. The network includes hospitals, physicians, therapists, behavioral health professionals and alternative care practitioners.

You and your covered dependents can receive care from any licensed doctor, hospital or other provider. However, when you use a contracting network provider, you will pay less out of pocket, you won't have to file any claims and you will receive the highest level of benefits. If you use a doctor outside the network, you'll still be covered, but your out-of-pocket costs may be significantly higher.

To find a contracting doctor or hospital, just go to *bcbsil.com* and use the Provider Finder, or call BlueCard® Access at 800-810-BLUE (800-810-2583) for help. Once you become a member, you can also call the toll-free customer service number on the back of your member ID card.

Medical Care

Your benefits may include coverage for*:

- physician office visits
- breast cancer screenings
- cervical cancer screenings
- inpatient hospital services
- muscle manipulation services
- outpatient hospital services
- physical, speech and occupational therapies
- outpatient surgery and diagnostic tests
- infertility treatment
- maternity care
- behavioral health and substance abuse
- hospital emergency medical and accident treatment

*Coverage levels vary by health plan, so refer to your plan documents for details.

The HMO Plans

The HMOs of Blue Cross and Blue Shield of Illinois (BCBSIL) provide the valuable benefits, member services and flexibility, along with the security of predictable copayments so there are no financial surprises. Unlike other plans, BCBSIL's HMOs do not require you to pay a deductible. Your employer may offer you the HMO Illinois plan, the BlueAdvantage℠ HMO plan or a choice between the two.

When you join one of the HMOs of Blue Cross and Blue Shield of Illinois, you choose a contracting medical group within your network and then a family practitioner, internist or pediatrician from your chosen medical group to serve as your primary care physician (PCP). Your PCP provides or coordinates your health care, helps you make informed decisions and, when necessary, makes referrals to specialists who are usually within your medical group network. Each specialist referral is authorized for a specific number of visits or timeframe (up to one year).

In addition to their PCP, female members also have the option of choosing a Woman's Principal Health Care Provider (WPHCP) to provide or coordinate their health care services. Your WPHC and PCP must be affiliated with or employed by your Participating Medical Group. Physicians in the same medical group do have a referral arrangement. You do not need a PCP referral to see your WPHCP.

HMOs offer valuable benefits with the security of predictable copayments.

HMO Networks

HMO Illinois offers access to one of the largest contracting health care provider networks in Illinois. In fact, your regular doctor may already be part of the network. If your doctor is not in the network and you are undergoing a course of evaluation and/or medical treatment or are in the second or third trimester of pregnancy when you join the plan, you may request transition of care benefits. Benefits for transitional services may be authorized for up to 90 days. After this period, all care must be transferred to a new PCP/medical group in the HMO network. Contact Member Services for more information.

The BlueAdvantage HMO contracting provider network is a subset of the HMO Illinois network. Although smaller, it offers a broad choice of contracting providers and is for members who are looking for a more affordable health care plan. And BlueAdvantage HMO members have access to the same contracting Illinois hospitals as HMO Illinois members for specialty care, with an approved referral from the member's contracting medical group.

The HMOs of Blue Cross and Blue Shield of Illinois have been awarded a Commendable Accreditation from the National Committee for Quality Assurance (NCQA). This accreditation level is awarded to plans that demonstrate levels of service and clinical quality that meet or exceed NCQA's rigorous requirements for consumer protection and quality improvement. The NCQA results are publicly reported in five categories:

• Access and Service • Qualified Providers • Staying Healthy • Getting Better • Living with Illness

If you have a question, visit bcbsil.com or call Member Services at 800-892-2803.

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Medical Care

The range of benefits includes coverage for:

- Physician office visits
- Outpatient surgery and diagnostic tests
- Breast cancer screening
- Cervical cancer screening
- Prostate cancer screening
- Colon cancer screening
- Inpatient hospital services
- Maternity care
- Outpatient hospital services
- Mental health and substance abuse – inpatient and outpatient treatment (Note: Physicians Care Network (PCN), Inc. members' mental health care is directly coordinated with the network mental health provider.)
- Rehabilitative therapy (such as physical, speech and occupational therapy)
- Inpatient and outpatient treatments

To find a medical group and PCP in either network, go to *bcbsil.com* and use the Provider Finder® or refer to a printed directory. You can request a directory by calling Member Services at the toll-free number on the back of your BCBSIL ID card. Each covered family member can choose a different medical group or PCP from the network. It's also easy to change your PCP or medical group for any reason. To select a different PCP within your existing medical group, just call the medical group. To change your medical group, call Member Services or use the Blue Access for Members online service at *bcbsil.com*. See Your Health Care Benefit Program booklet or call Member Services for more information.

Preventive Care

Another HMO benefit is coverage for preventive health services for children and adults, such as routine physicals, screenings, tests and immunizations, including childhood immunizations. Also, BCBSIL sends reminders to members to schedule flu shots, mammograms and Pap tests, and to have early childhood immunizations completed.

Vision Care

You and your covered dependents are eligible to receive an eye examination and contact lens evaluation, fitting and follow-up once every 12 months, for the cost of your PCP or wellness copayment. Your vision care benefits are available through Davis Vision℠, a leading national provider of routine vision care programs.

BlueCard® Urgent Care℠

This program covers HMO members traveling outside of Illinois who need medical attention for a condition that is not an emergency.

To find a contracting provider in the area in which you are traveling, call the BlueCard program toll-free at 800-810-BLUE (800-810-2583) or search the Blue Cross and Blue Shield Association's Web site at *bcbs.com*. You can then call the provider directly to make an appointment. You pay the applicable copayment at the time of service and don't need to submit claim forms.

If you have a question, visit bcbsil.com or call Member Services at 800-892-2803.

Guest Membership

This program covers members who are living out of the participating service area for at least 90 consecutive days. You can become a Guest Member with full benefits through a Blue Cross and Blue Shield HMO in another state. Guest Membership is a particularly valuable benefit for covered students who are living out of state while attending school or for members on extended travel out of state.

To find out if Guest Membership is available at your destination or to sign up with a host Blue Cross and Blue Shield HMO in another state, you must call Member Services before leaving home or before receiving any out-of-state services. If not, there will be no coverage for services received out of state. After applying, if you plan to continue with Guest Membership, you must renew it after a defined period of time.

Out-of-Area Coverage

The HMOs of Blue Cross and Blue Shield of Illinois give you access to health care benefits when traveling or temporarily living out of state.

Emergency Care

If you, as a prudent layperson with an average knowledge of health and medicine, need to go to the emergency room of any hospital, your care will be covered. When a medical emergency occurs, first try to call your PCP. Someone from your medical group is available 24 hours a day, seven days a week. Your PCP or another doctor in your medical group may be able to treat you in the office. If you are unable to call your PCP, go directly to the nearest hospital emergency room and notify your PCP as soon as possible.

If you are admitted, someone must contact your PCP immediately upon admission. Your emergency room copayment will be waived, but you will have to pay your inpatient hospital copayment, if applicable. Emergency care benefits are limited to the initial emergency treatment. To receive additional benefits, your PCP must provide or coordinate follow-up care.

Reconstructive Surgery

Federal and State of Illinois legislation require that group health plans and health insurers provide coverage for reconstructive surgery following a mastectomy. These laws state that health plans that cover mastectomies must also provide coverage in a manner determined in consultation with the attending physician and patient for reconstruction of the breast on which the mastectomy has been performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, and prostheses and treatment for physical complications for all stages of mastectomy care, including lymphedemas.

The HMOs of Blue Cross and Blue Shield of Illinois cover these procedures and annual mammograms when ordered by a member's primary care physician or Woman's Principal Health Care Provider, subject to the terms of the member's applicable health care benefit coverage. Visit us at *bcbsil.com* or call Member Services for more information.

Utilization Management

The HMOs of Blue Cross and Blue Shield of Illinois support the belief that the best people to determine what medical care you need are you and your doctor. BCBSIL does not get involved in deciding your course of treatment. This sets it apart from most other HMOs. Your doctor is encouraged to listen to your concerns and discuss all treatment options with you to help you make informed decisions. Your network medical group may review certain referrals or procedures for appropriateness of care. Your HMO doesn't get involved unless you request an appeal from BCBSIL because you disagree with decisions made by your PCP or medical group

Substance Abuse Treatment

Substance abuse treatment is provided at contracting facilities and a PCP referral is not needed. Call the number on the back of your ID card to locate a participating substance abuse provider.

If you have a question, visit bcbsil.com
or call Member Services at 800-892-2803.

Other Benefits for non-HMO plans

Your health care benefit plan travels with you wherever you go – across the country or around the world.

Preventive Care

Your coverage may include preventive care benefits for children and adults, including physical exams, diagnostic tests and immunizations. Check your group plan for the specific coverage.

Emergency Care

If you, as a prudent layperson (with an average knowledge of health and medicine) need to go to the emergency room of any hospital, your care will be covered subject to your plan's deductible and any applicable copayments or coinsurance. In an emergency, you should seek care from an emergency room or other similar facility. Call 911 or other community emergency resources to obtain assistance in life-threatening situations. Your group plan may require that you, a family member or friend contact BCBSIL if you are admitted to the hospital.

National Coverage

You have nationwide access to contracting providers in networks linked through the BlueCard® program when you or your covered dependents live, work or travel anywhere in the country. The national network includes more than 85 percent of all physicians and hospitals in the country. Be sure to use a BlueCard network provider to receive the highest level of benefits.

With the BlueCard program, there are two ways to locate contracting doctors and hospitals:

- Visit the Web site at *www.bcbsil.com* to find provider names and locations using the Provider Finder. Maps and driving directions are also available.
- Call the toll-free customer service number on the back of your ID card.

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Reconstructive Surgery Following Mastectomy

Federal and State of Illinois legislation require group health plans and health insurers to provide coverage for reconstructive surgery following a mastectomy. Specifically, these laws state that health plans that cover mastectomies must also provide coverage in a manner determined in consultation with the attending physician and patient for reconstruction of the breast on which the mastectomy has been performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, and prostheses and treatment of physical complications for all stages of mastectomy, including lymphedemas.

Your coverage may also include benefits for baseline and annual mammograms. Check your group plan documents for details.

Illinois Dependent Eligibility Mandate

Under new, Federal law, your dependents are eligible for health and/or dental coverage up to the dependent limiting age and may not be denied coverage due to marital, student or employment status before age 26. Check with your employer for additional details regarding eligibility requirements. In addition, eligible military personnel may not be denied coverage before age 30 under Illinois law. If you elect Blue*Choice* Select coverage, your dependents must live within the defined service area.

This Illinois law applies to all individual plans and insured group medical and/or dental plans, as well as self-insured municipalities, counties and schools. The law does not apply to self-funded national account groups or local non-municipal self-funded groups. If you have questions about this law, contact your benefits administrator.

International Coverage

When you travel outside the United States and need medical assistance services, call 800-810-BLUE (800-810-2583) or call collect to 804-673-1177 for information. Blue Cross and Blue Shield has contracts with doctors and hospitals in more than 200 countries. An assistance coordinator, in conjunction with a medical professional, can arrange your doctor's appointment or hospitalization, if necessary.

Providers that participate in the BlueCard Worldwide® program, in most cases, will not require you to pay up front for inpatient care. You are responsible for the out-of-pocket expenses such as a deductible, copayment, coinsurance and non-covered services. The doctor or hospital should submit your claim.

You also have coverage at non-contracting hospitals, but you will have to pay the doctor or hospital for care at the time of service, then submit an international claim form with original bills. Call the toll-free customer service number on your ID card for the address to send the claim. You can get a claim form from your employer, customer service or online at *www.bcbsil.com*.

Prescription Drugs

Save money by choosing generic drugs instead of brand drugs.

Prescription Drug Benefits

Non-HMO Plans

Your benefits include prescription drug coverage through Blue Cross and Blue Shield of Illinois. You have access to a national network of contracting pharmacies, which includes most national chain as well as independent pharmacies across the country. When you visit a contracting pharmacy and show your BCBSIL card, the claim is processed immediately at the time of purchase based on your medical plan deductible, coinsurance and out-of-pocket limitations. You are only responsible for your share of the discounted price of the medication.

Mail Service

You can receive up to a 90-day supply of maintenance medication delivered directly to you. Mail service claims are processed based on your medical plan deductible, coinsurance and out-of-pocket limitations, and you are only responsible for your share of the discounted price of the medication. You can print registration and order forms, request prescription refills and see the status of orders you've placed, learn more about generic drugs and more when you visit the Web site at ***www.bcbsil.com*** and log in to Blue Access® for Members.

Prescription Drug Card Program

HMO Plans

Your HMO benefits include prescription drug coverage. The outpatient prescription drug program is based on a tiered formulary structure. The formulary is a list of all generic drugs and a large selection of brand drugs. It is regularly reviewed and revised and is subject to change throughout the year. While coverage may vary depending on your health care benefit plan, you usually pay less for covered formulary drugs than for non-formulary drugs. The BCBSIL formulary structure provides coverage for nearly all drugs, even those that are not on the formulary. Check the formulary at ***www.bcbsil.com***.

Log in to Blue Access for Members℠ (BAM)

Your Online Resource

Would you like to know when your medical claims are paid and the payment amounts? Do you need to confirm who in your family is included under your coverage? BAM, the secure member portal from Blue Cross and Blue Shield of Illinois (BCBSIL), can help. Get immediate online access to health and wellness information, and:

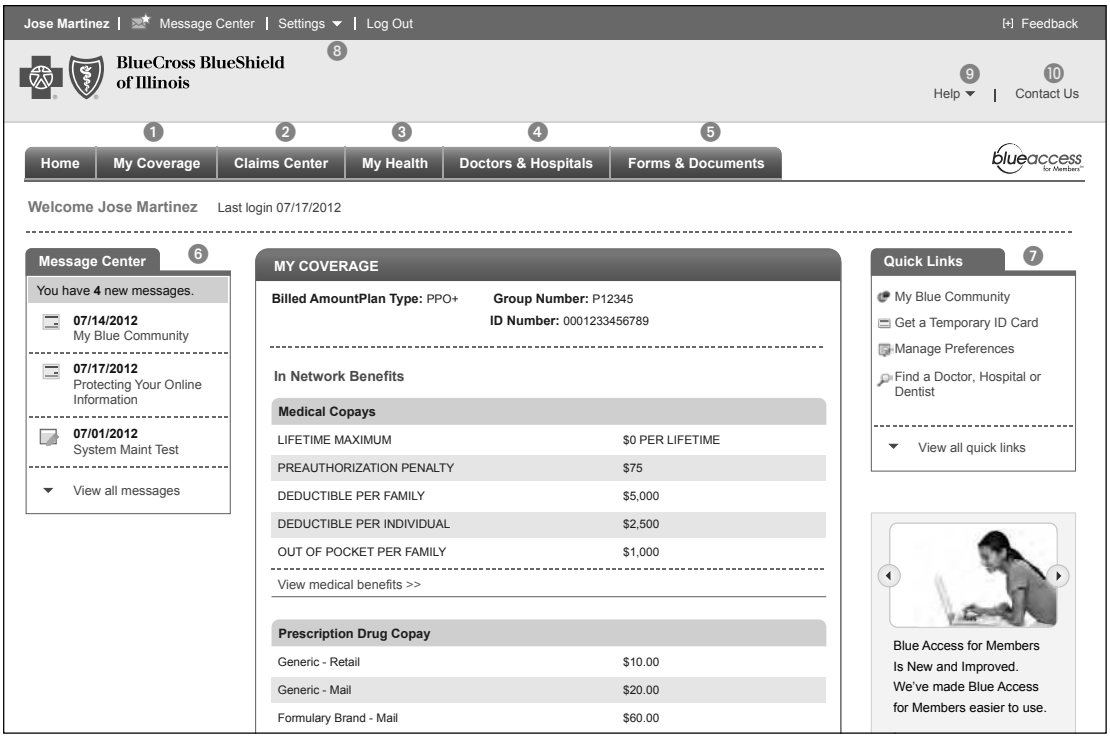
- Check the status of a claim and your claims history
- Confirm the family members who are covered under your plan
- View and print an Explanation of Benefits (EOB) statement for a claim
- Select an option to stop receiving EOBs by mail
- Set your preferences to receive notifications for claims status and wellness updates through emails or text alerts.
- Locate a doctor or hospital in the network
- Request a new or replacement member ID card or print a temporary member ID card
- Join My Blue Community®, a social network for BAM members

It's easy to get started

1. Go to bcbsil.com.
2. Click the Already a Member? tab. Then click the Register Now button in the BAM section.
3. Use the information on your BCBSIL ID card to complete the registration process.

Use BAM while you're on the go. Register or log in by going to bcbsil.com from your mobile device Web browser for secure and convenient access.

Find what you need at Blue Access for Members℠ (BAM)



1. **My Coverage:** Review benefit details for you and the family members covered under your plan.
2. **Claims Center:** View and organize details such as payments, dates of service, provider names, claims status and more.
3. **My Health:** Make more informed health care decisions by reading about health and wellness topics and researching specific conditions.
4. **Doctors & Hospitals:** Use Provider Finder® to locate a network doctor, hospital or other health care provider, and get driving directions.
5. **Forms & Documents:** Use the form finder to get medical, dental, pharmacy and other forms quickly and easily.
6. **Message Center:** Learn about updates to your benefit plan, and receive notification of pending and finalized claims via secure messaging.
7. **Quick Links:** Go directly to some of the most popular pages for information, such as medical coverage, replacement ID cards, manage preferences and more.
8. **Settings:** Set up notifications and alerts to receive updates via text messaging and email, review your member information, and change your secure password at anytime.
9. **Help:** Look up definitions of health insurance terms, get answers to frequently asked questions and find Health Care School articles and videos.
10. **Contact Us:** Submit a question and a Customer Service Advocate will respond by phone or through the message center.

Frequently Asked Questions

Q: What questions should I ask when selecting a doctor?

A: In addition to preliminary questions you'd ask a new doctor—such as "Are you accepting new patients?"—the following questions will help you evaluate whether a doctor is right for you:

- What is the doctor's experience in treating patients with the same health problems I have?
- Where is the doctor's office? Is there ample parking or is it close to public transportation?
- What are the regular office hours? Does the office have drop-in hours for urgent problems?
- How long should I expect to wait to see the doctor when I'm in the waiting room?
- Are routine lab tests and X-rays performed in the office, or will I have to go elsewhere?
- Which hospitals does the doctor use?
- If this is a group practice, will I always see my chosen doctor?
- How long does it usually take to get an appointment?
- How do I get in touch with the doctor after office hours?
- Can I get advice about routine medical problems over the phone or by e-mail?
- Does the office send reminders for routine preventive tests, like cholesterol checks?

Q: Whom do I call with questions about my benefits?

A: Call customer service at the toll-free number on the back of your member ID card.

Q: How do I find a contracting network doctor or hospital?

A: Go to ***www.bcbsil.com*** and use the Provider Finder® or call customer service at the toll-free number on the back of your member ID card.

Q: What should I bring to my first appointment?

A: Your first appointment is an opportunity to share information about your health with your new doctor, so bring as much medical information as possible, including:

- *Medical records and insurance card* – If you are undergoing treatment when you change doctors, your medical records are especially important to your new doctor. Your BCBSIL member ID card provides information about copayments, billing and customer service phone numbers.
- *Medications* – Give your new doctor information on prescription and over-the-counter medications, including any herbal medications you take. Be sure to include the name of the medication, the dosage, how often you take it and why.
- *Special needs* – Make a list of medical equipment and devices you use, including wheelchairs, oxygen, glucose monitors and glucose strips. Be prepared to explain how you use them, not only to make sure you have the equipment you need, but also to avoid any disruption in your care.

Q: Are my medical records kept confidential?

A: Yes. Blue Cross and Blue Shield of Illinois is committed to keeping specific member information confidential. Anyone who may need to review your records is required to keep your information confidential. BCBSIL may need to review your medical record or claims data (for example, as part of an appeal that you request). If so, precautions are taken to keep your information confidential. In many cases, your identity will not be associated with this information.

21796.0209

Be Smart. Be Well.®

You can increase your odds of living better and living longer by making smart health and safety choices.

Be Smart. Be Well. is a unique Web site dedicated to helping you be safe and healthy. Be Smart. Be Well. features engaging video documentaries of the personal lessons learned by real people. The goal of Be Smart. Be Well. is simple: to give you the information and resources you need to make an immediate and positive impact on your everyday life.

Highlights of the site include:

- Simple steps you can take to live healthier
- Links to useful resources
- Information provided by medical professionals
- Timely newsfeeds from national media

Numerous health and safety topics including mental health, childhood obesity, drug safety and caregiving are presented on the site. New topics are continually added.

Be Smart. Be Well. is sponsored by Health Care Service Corporation, the largest customer-owned health insurer in the United States, with more than 12 million members in its Blue Cross and Blue Shield Plans in Illinois, New Mexico, Oklahoma and Texas.

Be sure to join the daily discussion on Twitter at *twitter.com/bsbw* and visit us on You Tube at *www.youtube.com/besmartbewell*.

Be Smart. Be Well. Know the facts.
Visit www.besmartbewell.com today.

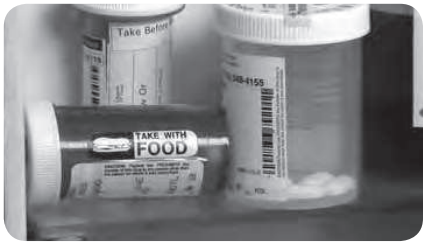
where awareness and prevention meet

be smart. be well.®

Caregiving

Childhood Obesity

Drug Safety



BlueCross BlueShield of Illinois
BlueCross BlueShield of New Mexico
BlueCross BlueShield of Oklahoma
BlueCross BlueShield of Texas

Experience. Wellness. Everywhere.℠

This information is not intended to be a substitute for professional medical advice. If you are under the care of a doctor and receive advice contrary to this information, follow the doctor's advice. See your doctor if you are experiencing any symptoms or health problems.

21993.0309

Understanding Your EOB

A Guide to Reading Your Explanation of Benefits Statement

An Explanation of Benefits (EOB) Statement is a notification form provided to members when a health care benefits claim is processed by Blue Cross and Blue Shield of Illinois (BCBSIL). The EOB displays the expenses submitted by the provider and shows how the claim was processed.

The EOB has four major sections:

- **Claim Information** includes the member and patient name, the member's group and ID numbers, and the claim number.
- **Summary** highlights the financial information – the amount billed, total benefits approved and the amount you may owe the provider.
- **Service Information** identifies the health care facility or physician, dates of service and charges.
- **Coverage Information** shows what was paid to whom, what discounts and deductions apply, and what part of the total expense was not covered.

The EOB may include additional information.

- **Information About Amounts Not Covered** will show what benefit limitations or exclusions apply.
- **Information About Out-Of-Pocket Expenses** will show an amount when a claim applies toward your deductible or counts toward your out-of-pocket expenses.
- **Information About Appeals** explains your rights regarding review of claim denials.
- **Fraud Hotline** is a toll-free number you can call if you think you are being charged for services you did not receive or if you suspect any fraudulent activity.

Your EOBs are Always Available Online!

Sign up for Blue Access® for Members (BAM) at *www.bcbsil.com* for quick, convenient and confidential access to your claim information and history. To support our commitment to eco-friendly business practices, you can choose to opt out of receiving EOBs by mail. This saves resources and offers you additional confidentiality. Just go to BAM, click on *User Profile* and change your *User Preferences*.

20154.0109

Sample EOB

BlueCross BlueShield of Illinois
300 East Randolph
Chicago, Illinois 60601-5099

Explanation of Benefits (EOB). **This is not a bill.**
1 **HEALTH CARE SERVICE CORP**
2 06-02-08

4 ANTHONY DOE
100 BLUEBIRD LANE
CHICAGO, IL 60601-7332

3 Customer Service: 1-800-XXX-XXXX

5 **Check here for BCBSIL messages.**

Summary

11	Total Billed:	$45.00
	Total Benefits Approved:	**$16.20**
	Amount You May Owe Provider:	$1.80

Claim Information

6	Member Name:	Anthony Doe
7	**Group No.:**	**12345**
8	**Identification No.:**	**ABC123454569**
9	Claim No.:	2020000000000X
10	Patient Name:	Anthony Doe

The following shows how this claim was processed.

Service Information

12 Service Description	13 Service Date	14 Amount Billed	15 Not Covered	16 Covered
IMAGING RADIOLOGISTS LLC				
Medical Emerg X-Ray	05-21-08	45.00	27.00 (1)	18.00
17 **Totals**		**$45.00**	**$27.00**	**$18.00**

Coverage Information

Totals	**$45.00**	**$27.00**	**$18.00**
18 PARTICIPATING PROVIDER OPTION (PPO REDUCTION)		-$27.00	
19 **Deductions**			
Your 10% Coinsurance Amount.....		1.80	
Total Deductions			**-$1.80**
20 **Total Benefits Approved**			**$16.20**
21 **Amount You May Owe Provider**			**$1.80**
22 Total covered benefits approved for this claim: $16.20 to IMAGING RADIOLOGISTS LLC on 06-02-08.			

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

151,247 002573

Sample EOB

1. Account name (member's company or organization)
2. Date claim was finalized
3. Toll-free number to call for additional information
4. Member's name and mailing address
5. BCBSIL messages
6. Member's name
7. Employer or group identification number*
8. Member number that appears on the ID card*
9. Claim number*
10. Person who received the services*
11. Summary box, including the total amount billed by the provider for the services, the benefits approved and paid by BCBSIL, and the remainder you may owe. (See also 14, 20 and 21).
12. Provider name (top line) and description of service (below)
13. Beginning and end service dates
14. Amount billed by the provider for each service
15. Portion of the billed amount not covered by the plan (a footnote explains the reason)
16. Amount covered by the plan*
17. Total charges included on this claim
18. Plan reductions subtracted from billed amount, such as PPO allowances
19. Deductible and copayment or coinsurance amounts
20. Payment approved before benefits are coordinated with other insurers, such as Medicare
21. Amount the member may be responsible for paying
22. Total benefit approved for provider

* Please provide this information when contacting us about a claim.

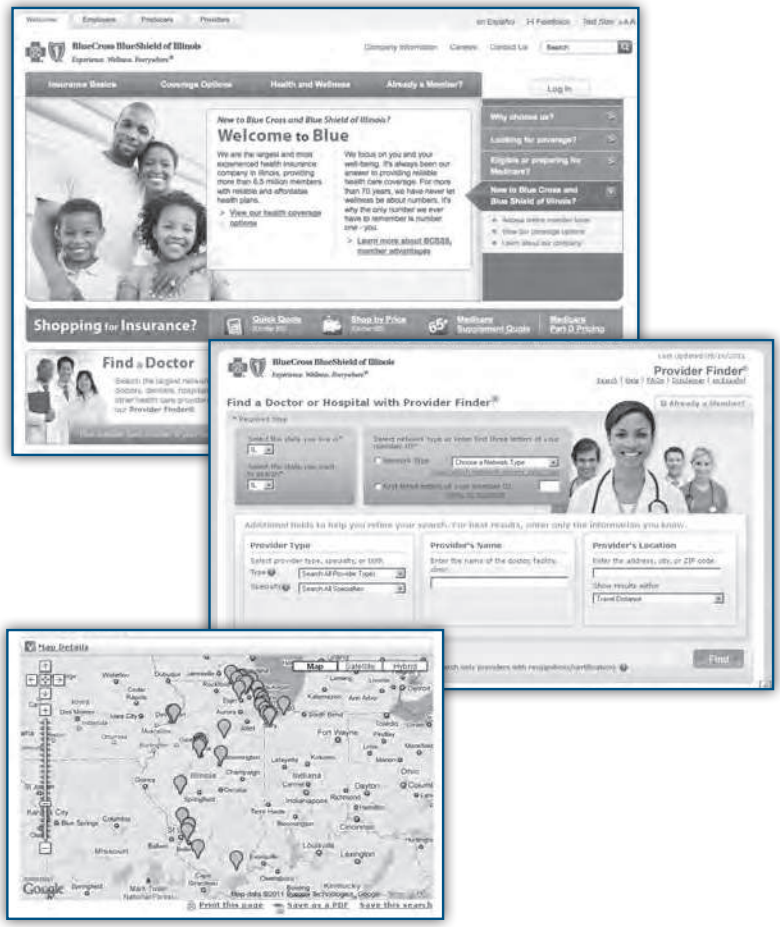
Not all EOBs are the same. The format and content of your EOB depends on your benefit plan and the services provided. Deductible and copayment amounts vary.

Quick and Easy Ways to Find a Doctor

Use Provider Finder®, a reliable and convenient tool, to locate doctors, dentists and pharmacies in your network. Filter search results by provider type, specialty, network type, ZIP code, language and gender. Get directions from Google Maps™, too. It's now faster and simpler to do than ever before!

Online

Go to bcbsil.com and click on Find a Doctor. The improved search experience on Provider Finder means you need fewer clicks and required fields to get your results!



On your mobile device - New!

Go to bcbsil.com from your mobile phone's Web browser and click on Find a Doctor or Hospital. Or download the Provider Finder App for your iPhone® or Android® phone. If you use your GPS location or input a ZIP code, the App can pinpoint the closest provider locations for you.

On the phone

If you prefer, call a Blue Cross and Blue Shield of Illinois (BCBSIL), a division of Health Care Service Corporation, Customer Service Advocate at the toll-free telephone number on the back of your BCBSIL member ID card for help in locating a provider.

Blue Access Mobile℠

Blue Access Mobile brings convenient, secure access to your mobile phone.

From your mobile phone Web browser, you can:

- Register or log in to your secure member site – Blue Access for Members℠ – to view coverage details, access identification (ID) cards, check claims status, manage your user profile and view health and wellness information
- Download the Provider Finder® app to find an in-network doctor or hospital.
- Sign up for text or email notifications, tips and reminders
- Access Health Care 101 to view general health insurance information and terminology
- Shop for insurance and get a quote before applying

It is easy to experience Blue Access Mobile. Simply go to bcbsil.com from your mobile phone Web browser.

There is no registration required to access the mobile site. However, BCBSIL members must enter their user name and password to log in to Blue Access for Members.

bcbsil.com/mobile

Q&A Prescription Drug Formulary

What is a formulary?

The Blue Cross and Blue Shield of Illinois formulary, which your prescription drug benefit plan is based on, is a regularly updated list of preferred drugs selected based on the recommendations of a committee comprised of individuals from throughout the country who hold a medical or pharmacy degree. U.S. Food and Drug Administration (FDA)-approved drugs are chosen based on efficacy, safety, uniqueness and cost-effectiveness. The formulary includes all generic drugs and a select group of brand drugs.

What are the advantages of using the formulary?

Your copayment/coinsurance amount for covered formulary drugs is usually lower than for non-formulary drugs. You have benefits for most covered medications that are not on the formulary, but you may pay more out-of-pocket. The formulary is a reference for your doctor when prescribing medications. However, it is solely up to you and your physician to determine the medication that is best for you.

What are the advantages of using generic drugs?

Generics are recognized as safe and effective medications. Generics cost less because manufacturers do not have to recover an investment in research and development. Therefore, you usually pay less for a generic drug than for a brand medication. A generic can usually be substituted for a brand drug if it contains the same active ingredients, the same strength and dosage form and produces the same results. Only your doctor can make prescribing decisions for you. Talk to your doctor or pharmacist to find out if a generic drug is available and right for you.

How do I know if a drug is on the formulary and what my cost will be?

On the following pages are some commonly prescribed generic and formulary brand medications. If a drug you are looking for is not on the list, search the formulary at *bcbsil.com* or call the Pharmacy Program number on the back of your ID card.

Your particular prescription drug benefit plan and whether or not the drug is on the formulary will determine the amount you pay. To find out what you will pay, visit our website at *bcbsil.com* or call the Pharmacy Program number on the back of your ID card.

What are drug dispensing limits?

Based on FDA-approved dosage regimens and manufacturer's product packaging, certain medications have dispensing limits. This means that only a specific quantity of medication is covered per prescription or in a given time period. For example, coverage for the osteoporosis drug Actonel® (risedronate) is limited to 30 tablets per 30 days because the FDA-approved labeling states that the recommended dose is one 5 mg oral tablet taken daily.

What if I have questions?

Call the Pharmacy Program number on the back of your ID card, 24 hours a day, 7 days a week, or visit *bcbsil.com*. Drug safety information is also available at *besmartbewell.com/drugsafety*.

April 2013
Commonly Prescribed Formulary Medications

This list is a sample of commonly prescribed generic and formulary brand drugs. Refer to the Blue Cross and Blue Shield of Illinois Prescription Drug Formulary at *bcbsil.com* for a more comprehensive and up-to-date list. The online formulary is updated after new generic drugs become available and also on a regular basis. The formulary may contain medications not covered under your prescription drug benefit plan. In addition, prescription versions of over-the-counter (OTC) medications may not be covered based on your prescription drug benefit plan. If you have questions about your prescription drug benefit, call the Pharmacy Program number on the back of your ID card.

CARDIOVASCULAR

ACE Inhibitors/Combinations
amlodipine/benazepril
benazepril/benazepril HCT
captopril/captopril HCT
enalapril/enalapril HCT
fosinopril/fosinopril HCT
irbesartan/irbesartan HCT
lisinopril/lisinopril HCT
quinapril/quinapril HCT
ramipril
trandolapril

Angiotensin II Receptor Blockers
losartan/losartan HCT
valsartan HCT
BENICAR/BENICAR HCT

Beta-Blockers
acebutolol
atenolol
bisprolol/bisprolol HCT
carvedilol
labetalol
metoprolol/metoprolol ER
propranolol
INNOPRAN XL

Calcium Channel Blockers
amlodipine
diltiazem/XR/SR
nifedipine ER
verapamil/SR/ER

Cholesterol Lowering Drugs
atorvastatin
cholestyramine
colestipol pkt
fenofibrate
gemfibrozil
lovastatin
pravastatin
simvastatin
CRESTOR
NIASPAN
TRICOR
TRILIPIX
WELCHOL

DEPRESSION

SSRIs
citalopram
escitalopram
fluoxetine
paroxetine
sertraline

Other Antidepressants
amitriptyline
bupropion/SR/XL
bupropion ext-release 24 hr
mirtazapine/ODT
nefazodone
trazodone
venlafaxine/XR

DIABETES
acarbose
metformin/XR
metformin/glyburide
PRANDIN
VICTOZA

Dipeptidyl Peptidase 4 Inhibitors
JANUMET/JANUMET XR
JANUVIA
JUVISYNC
KOMBIGLYZE XR
ONGLYZA

Sulfonylureas
glimepiride
glipizide/XL
glyburide/glyburide micronized

Insulin Products
HUMALOG/HUMULIN
LANTUS
LEVEMIR
NOVOLIN/NOVOLOG

Monitoring Kits/Strips & Syringes
ACCU-CHEK STRIPS & KITS
ACCU-CHEK LANCETS
BAYER BREEZE STRIPS
BAYER CONTOUR STRIPS
BAYER MICROLET LANCETS
BD NEEDLES/SYRINGES
CHEMSTRIP BG STRIPS & KITS

GASTROINTESTINAL

H2 Receptor Antagonists
cimetidine
famotidine
ranitidine

Proton Pump Inhibitors
lansoprazole/ODT
omeprazole
pantoprazole
NEXIUM

ANTI-INFECTIVE AGENTS

Antibacterials
amoxicillin
amoxicillin/clavulanate
ampicillin
azithromycin tabs/susp
cefaclor
cefadroxil
cefdinir
cefprozil
cefuroxime
cephalexin
ciprofloxacin
doxycycline
EES/sulfisoxazole
erythromycin
levofloxacin
penicillin VK
tetracycline
tmp-smz DS

Antifungals/Onychomycosis
terbinafine
voriconazole

Antivirals/Herpes
acyclovir
valacyclovir

LOW MOLECULAR WEIGHT HEPARIN
enoxaparin

MIGRAINE

Triptans
naratriptan
rizatriptan
sumatriptan
MAXALT/MAXALT-MLT

OPHTHALMIC

Antibacterial
ofloxacin ophth soln
polymyxin B/trimethoprim
tobramycin
VIGAMOX

April 2013
Commonly Prescribed Formulary Medications

Glaucoma
brimonidine 0.15%, 0.2%
dorzolamide soln
latanoprost
timolol maleate soln
ALPHAGAN P 0.1%
AZOPT
LUMIGAN
TRAVATAN Z

Other Eye Products
azelastine soln
diclofenac soln
ketorolac soln 0.4%, 0.5%
tobramycin/dexamethasone susp
PATADAY
TOBRADEX OINT
ZYLET

PAIN/ARTHRITIS
Anti-inflammatory Agents
diclofenac
etodolac
ibuprofen
indomethacin
meloxicam
nabumetone
naproxen
oxaprozin
sulindac
CELEBREX
HUMIRA

RESPIRATORY
Allergy Drugs
All generically available antihistamine/decongestant combinations that require a prescription are on the formulary.

azelastine
fexofenadine
fluticasone
levocetirizine
triamcinolone
ASTEPRO
NASONEX

Asthma Drugs
montelukast
zafirlukast
ADVAIR DISKUS/ADVAIR HFA
ASMANEX
DULERA
FLOVENT DISKUS/FLOVENT HFA
FORADIL AEROLIZER
PROAIR HFA
QVAR
SYMBICORT
VENTOLIN HFA

Cough and Cold
All generically available cough/cold medications that require a prescription are on the formulary.

Miscellaneous
ATROVENT HFA
COMBIVENT
COMBIVENT RESPIMAT
ipratropium/albuterol sulfate
SPIRIVA HANDIHALER

SLEEP AIDS
zaleplon
zolpidem/ER

THYROID REPLACEMENT
levothyroxine – includes Levoxyl*

UROLOGIC DISORDERS
Benign Prostatic Hypertrophy
doxazosin
tamsulosin
terazosin

Urinary Incontinence
oxybutynin/ext-release
tolterodine
DETROL LA
VESICARE

Others
finasteride
AVODART

WOMEN'S HEALTH
Contraceptives
Monophasic
EE/desogestrel (Apri*)
EE/drospirenone (Gianvi*, Ocella*, Zarah*)
EE/levonorgestrel (Aviane*, Levora*)
EE/norethindrone (Necon*, Necon 1/35*, Nortrel*, Nortrel 1/35*)
EE/norgestimate (Mononessa*, Sprintec*)
EE/norgestrel (Low-Ogestrel*)

Biphasic
EE/desogestrel (Kariva*)
EE/norethindrone (Necon 10/11*)

Triphasic
EE/desogestrel (Velivet*)
EE/levonorgestrel (Trivora*)
EE/norethindrone (Necon 7/7/7*, Nortrel 7/7/7*)
EE/norgestimate (Tri-Sprintec*, Trinessa*)

Progestin Only
norethindrone (Errin*, Jolivette*)

Others
levonorgestrel 0.75 mg
NUVARING
ORTHO EVRA

Hormone Therapy
estradiol
estradiol/norethindrone acetate
estropipate
medoxyprogesterone
norethindrone
progesterone micronized
ESTRADERM
PROMETRIUM
VIVELLE DOT

Miscellaneous
alendronate
ibandronate
ACTONEL
EVISTA
ZEMPLAR

Formulary brand drugs are noted with names in UPPERCASE. Certain generic drug products are listed by their proprietary name, and are indicated with an asterisk (*). EE = ethinyl estradiol

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Save when you use **Generic Drugs**

Talk to Your Doctor and Pharmacist

Your doctor uses clinical knowledge and judgment to prescribe drugs that meet your needs. The next time your doctor writes you a prescription, consider asking if a generic is available and right for you. When purchasing a prescription, you can tell the pharmacist that you would like the generic equivalent, if available, unless your doctor indicates otherwise.

Frequently Asked Questions

Are generic drugs as safe as brand drugs? Generic drugs are reviewed and approved by the U.S. Food and Drug Administration (FDA), just as brand drugs are. According to the FDA, compared to a brand drug, a generic equivalent:

- is chemically the same
- works the same in the body
- meets the same standards set by the FDA
- is as safe and effective.

Why do generic drugs cost less? Generic drugs tend to cost less than the equivalent brand drug because the companies that make them do not have to recover the costs of research and development. On average, generic drugs cost 30 to 80 percent less than their brand counterparts.* Please keep in mind, however, that your out-of-pocket expense will be determined by your particular benefit plan.

Is there a generic drug available for my condition? Most likely. Sixty-three percent of all prescriptions dispensed in the United States are filled with generic drugs.**

A Good Choice

Your doctor will determine the appropriate medication for you. Consider asking if a generic equivalent is available for your prescription. Remember, you get a drug with the same active ingredients at the same dosage as the brand drug – usually at a lower cost.

Below are some of the most commonly prescribed brand drugs and their generic equivalents. Ask your physician to approve the generic equivalent whenever possible by writing the generic name on the prescription.

Common Brand Drugs and Their Generic Equivalents

Brand Name	Generic Name
Altace	ramipril
Amaryl	glimepiride
Ambien	zolpidem
Ativan	lorazepam
Calan SR	verapamil SR
Cardizem	diltiazem ER
Celexa	citalopram
Coumadin	warfarin
Diabeta	glyburide
Dilantin	phenytoin
Effexor	venlafaxine
Flonase	fluticasone
Fosamax	alendronate
Glucophage	metformin
Glucotrol	glipizide
Hytrin	terazosin
Imitrex	sumatriptan
Lasix	furosemide
Lopid	gemfibrozil

Brand Name	Generic Name
Mevacor	lovastatin
Micronase	glyburide
Norvasc	amlodipine
Paxil	paroxetine
Pepcid	famotidine
Pravachol	pravastatin
Prilosec	omeprazole
Prinivil	lisinopril
Procardia	nifedipine
Procardia XL	nifedipine XL
Proventil	albuterol
Prozac	fluoxetine
Retin-A	tretinoin
Risperdal	risperidone
Sonata	zaleplon
Synthroid	levothyroxine
Timoptic	timolol

Brand Name	Generic Name
Toprol XL	metoprolol ext-release
Tylenol with codeine	acetaminophen w/codeine
Ultram	tramadol
Vasotec	enalapril
Ventolin	albuterol
Wellbutrin	bupropion
Wellbutrin XL	bupropion ext-release
Xanax	alprazolam
Yasmin	drospirenone/ethinyl estradiol; branded generic called Ocella
Zantac	ranitidine
Zestril	lisinopril
Zocor	simvastatin
Zoloft	sertraline
Zovirax	acyclovir

As always, you should discuss with your physician questions or concerns about any drugs you are taking. Your doctor can determine whether a generic drug is appropriate for you.

**The National Association of Chain Drug Stores*
***IMS Health*

Specialty Medications

Blue Cross and Blue Shield of Illinois (BCBSIL) has arranged for Prime Specialty Pharmacy to support members who require specialty medication and help them manage their therapy.*

Specialty medications are generally prescribed to treat chronic, complex medical conditions, such as multiple sclerosis, hepatitis C and rheumatoid arthritis. These medications are typically received by injection or infusion, but may be topical or taken by mouth. Specialty drugs often require careful adherence to a treatment plan and have special handling or storage requirements and may not be stocked by retail pharmacies.

Some specialty medications must be given by a health care professional, while others are self-administered. Medications that require professional services for administration are usually covered under your medical benefit. Your doctor will order these medications. Coverage for self-administered specialty medications is usually provided through your pharmacy benefit. Your doctor should write or call in a prescription for self-administered specialty medications for receipt from a specialty pharmacy provider.

Examples of Self-administered Specialty Medications

The chart to the right shows some conditions self-administered specialty medications may be used to treat, along with sample medications. This list is not all-inclusive and may change from time to time. Visit bcbsil.com to see the current list of specialty medications.

Condition	Sample Medications**
Osteoporosis	Forteo
Cancer (oral)	Gleevec, Nexavar, Sprycel, Sutent, Tykerb
Growth Hormones	Genotropin, Humatrope, Norditropin, Omnitrope, Tev-Tropin
Hepatitis C	Copegus, Infergen, Intron-A, Pegasys, Peg-Intron
Multiple Sclerosis	Avonex, Betaseron, Copaxone, Rebif
Rheumatoid Arthritis/Psoriasis	Enbrel, Humira, Kineret

Other conditions that specialty medications may be used to treat include cystic fibrosis, hemophilia, infertility, lung disorders and pulmonary arterial hypertension.

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Support in Managing Your Condition: Prime Specialty Pharmacy

Through Prime Specialty Pharmacy, you can have your covered self-administered specialty medication delivered directly to you, or to your doctor's office. When you get your specialty medication through Prime Specialty Pharmacy, you receive support in managing your therapy – at no additional charge – including:

- Assistance with coverage between you, your doctor and BCBSIL
- Convenient delivery of medication to you or your doctor's office
- Information about your particular condition and about managing potential medication side effects
- Syringes, sharps containers and other supplies with every shipment for self-injectable medications
- 24/7/365 customer service phone access

Ordering Through Prime Specialty Pharmacy

To begin using Prime Specialty Pharmacy, call 877.627.MEDS (6337). If you currently use a self-administered specialty medication, you can have your existing prescription transferred to Prime Specialty Pharmacy. If you have a new prescription, Prime Specialty Pharmacy can provide you more information about submitting the prescription or having your doctor do so. Your doctor may also order office-administered specialty medication through Prime Specialty Pharmacy.

Please note that some members may not have coverage for self-administered specialty medications. In addition, the list of specialty medications may include drugs that are not covered under your benefit because of specific exclusions. Check your benefit booklet for details, or call the number on the back of your member ID card with questions.

Call Prime Specialty Pharmacy at 877.627.MEDS (6337) to order. Have your member ID card and the following information ready:

- Name, address, phone number
- Name of medication
- For existing prescriptions, your current pharmacy's name and phone number, and the prescription number
- Doctor's name, phone and fax numbers

Receiving Specialty Medications

Since many specialty medications have unique shipping or handling requirements, shipments will be arranged with you through Prime Specialty Pharmacy. Medications are shipped in plain, secure, tamper-resistant packaging.

Prior to your scheduled refill date, you may be contacted to:

- Confirm your medication, dosage and the delivery location
- Review any prescription changes your doctor may have ordered
- Discuss any side effects you may be experiencing

If you need assistance, you can reach Prime Specialty Pharmacy at 877.627.MEDS (6337).

*Prime Therapeutics Specialty Pharmacy LLC (Prime Specialty Pharmacy) is a wholly owned subsidiary of Prime Therapeutics LLC, a pharmacy benefit management company. Blue Cross and Blue Shield of Illinois contracts with Prime Therapeutics to provide pharmacy benefit management, prescription home delivery and specialty pharmacy services. Blue Cross and Blue Shield of Illinois, as well as several other independent Blue Cross and Blue Shield Plans, has an ownership interest in Prime Therapeutics.

**Third-party brand names are the property of their respective owners.

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24/7 Nurseline* – Around-the-Clock, Toll-Free Support

The 24/7 Nurseline can help you figure out if you should call your doctor, go to the ER or treat the problem yourself.

Health concerns don't always follow a 9-to-5 schedule. Fortunately, registered nurses are on call at (800) 299-0274 to answer your health questions, wherever you may be, 24 hours a day, seven days a week.

The 24/7 Nurseline's registered nurses can understand your health concerns and give general health tips. Get trusted guidance on possible emergency care, urgent care, family care and more.

When should you call?

The toll-free Nurseline can help you or a covered family member get answers to health problem questions, such as:

- *Asthma, back pain or chronic health issues*
- *Dizziness or severe headaches*
- *High fever*
- *A baby's nonstop crying*
- *Cuts or burns*
- *Sore throat*

Plus, when you call, you can access an audio library of more than 1,000 health topics—from allergies to women's health—with more than 600 topics available in Spanish.

Note: For medical emergencies, call 911 or your local emergency services first. This program is not a substitute for a doctor's care. Talk to your doctor about any health questions or concerns.

*The 24/7 Nurseline is not available to HMO members.

Get the information you need, just when you need it.

Well onTarget℠

a New Way to Experience Wellness

Wellness is more than healthy eating and working out. It involves making healthy choices that enrich your mind, body and spirit. Well onTarget is designed to give you the support you need to make these choices. All while rewarding you for your hard work.

Well onTarget offers personalized tools and resources to help all members—no matter where you may be on the path to health and wellness.

Liveon Member Wellness Portal

The heart of Well onTarget is the Liveon portal. It uses the latest technology to offer you an enhanced online experience. This engaging portal links you to a suite of innovative programs and tools.

- **onmytime Self-directed Courses**
  Online courses let you work at your own pace to reach your health goals. Learn more on nutrition, fitness, weight management, tobacco cessation and stress. Track your progress as you make your way through each lesson. Reach your milestones and earn Life Points.
- **Health and Wellness Content**
  Health library teaches and empowers through evidence-based, user-friendly articles.
- **Tools and Trackers**
  Interactive tools help keep you on course while making wellness fun. Use food and workout diaries, health calculators and medical and lifestyle trackers.

onmyway™* Health Assessment (HA)

The HA features adaptable questions to learn more about you. After you take the HA, you will get a personal wellness report. The confidential record offers tips for living your healthiest life. Your answers will be used to tailor the Liveon portal with the programs that can help you reach your goals.

Life Points Program

Life Points will help motivate you to maintain a healthy lifestyle. Earn points by taking part in wellness activities. Points can be redeemed in the new online shopping mall. Real-time granting of points lets you instantly use your points. To earn a larger reward, you can add to your point total at checkout.

Fitness Program

Fitness can be easy, fun and affordable. The Fitness Program is a flexible membership program that gives you unlimited access to a nationwide network of fitness centers. With more than 8,000 participating gyms on hand, you can work out at any place or at any time. Choose a gym close to home and one near your office. Other program perks are:

- No long-term contract required. Membership is month to month. Monthly fees are $25 per month per member, with a one-time enrollment fee of $25.
- Automatic withdrawal of monthly fee.
- Online tools for locating gyms and tracking visits.
- Earn bonus Life Points for joining the Fitness Program. Rack up more points with weekly visits.

Sign up today! Call toll-free at 888-762-BLUE (2583), Monday through Friday, 8 a.m. – 9 p.m. in any continental U.S. time zone.

91518.0912

Blue365®

A Discount Program for Members

Blue365 is just one more advantage of being a Blue Cross and Blue Shield of Illinois (BCBSIL) member. With this program, you can save money on health care products and services that are most often not covered by your benefit plan. There are no claims to file and no referrals or pre-authorizations.

Blue365 has a range of new features and greater discounts from top national and local retailers on fitness gear, gym memberships, family activities, healthy eating options and much more. Once you register on the Blue365 website at ***blue365deals.com/BCBSIL,*** you will receive weekly "Featured Deals," which will offer additional discounts from leading health companies and online retailers that are available for a short period of time.

Davis Vision℠
877-393-8844

Save on eyeglasses, as well as contact lenses, laser vision correction services, examinations and accessories. For a list of Davis Vision providers near you, go to ***bcbsil.com,*** click Find a Doctor then select Find a Vision Provider. The Davis Vision network consists of major national and regional retail locations as well as independent ophthalmologists and optometrists. You and your eligible dependents can receive discounts on laser vision correction services through the TLC/ TruVision network.

TruVision
877-882-2020

Jenny Craig®
877-JENNY70 (877-536-6970)

Jenny Craig can help you reach your weight-loss goals. You will get one-on-one support given by a trained weight-loss expert. Your consultant will give you a tailored program based on the essential components of successful weight management: food, body, mind. You can meet with your consultant in person at a local center. Or you can enjoy the ease of the Jenny Craig At Home program.

For more great deals or to learn more about Blue365, visit blue365deals.com/BCBSIL.

Life Time®′ Fitness

Life Time Fitness offers a total health fitness experience no matter your fitness level, interests, schedule or budget. For new members, Life Time Fitness offers a $0 enrollment fee when you sign up online.*

Procter & Gamble (P&G) Dental Products 877-333-0121

Get savings on dental packages containing the latest in Oral B®′ power toothbrushes and Crest®′ products. The dental packages from P&G can help you improve the health of your teeth and gums. Packages may contain items such as an electric toothbrush, mouth rinse, floss, and many more.

TruHearing®′ 800-687-4617

Save on digital hearing aids through TruHearing. Get a hearing test at no extra charge when performed to fit a hearing aid. Enjoy a 45-day,money-back guarantee and a three-year warranty. Also get a choice of hearing aid styles at a number of price levels and enough batteries to last a year when you buy a hearing aid.

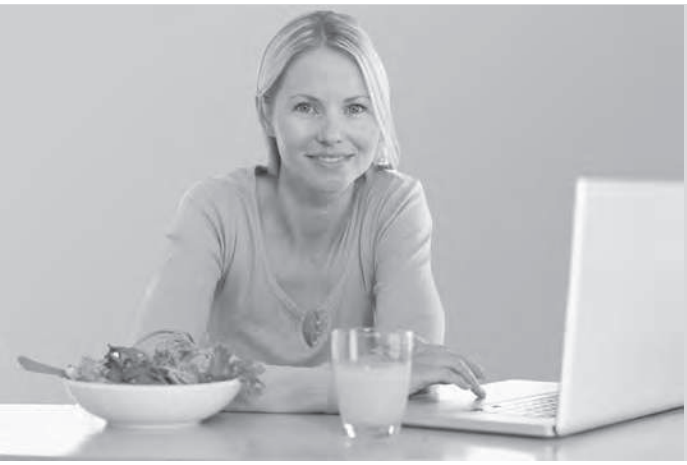
The relationship between these vendors and Blue Cross and Blue Shield of Illinois (BCBSIL) is that of independent contractors.

* Proof of Blue Cross and Blue Shield of Illinois coverage is needed. The $0 enrollment fee offer is only for new members who enroll online at blue365deals.com/BCBSIL. A $35 administrative fee applies to all memberships. Monthly dues and taxes may also apply. Members' prices, dues and fees may change at any time. Offer expires September 1, 2013. Other rules may apply. Always check with the Life Time Fitness club in your area for the most up-to-date offer. Offer not available in Minnesota.

Blue365 is a discount program only for BCBSIL members. This is NOT insurance. Some of the services offered through this program may be covered under your health plan. Please check your benefit booklet or call the customer service number on the back of your ID card for specific benefit facts. Use of Blue365 does not change your monthly payment, nor do costs of the services or products count toward any maximums and/or plan deductibles. Discounts are only given through vendors who take part in this program. BCBSIL does not guarantee or make any claims or recommendations about the program's services or products. You may want to talk to your doctor before using these services and products. BCBSIL reserves the right to stop or change this program at any time without notice.

Well onTarget℠

Life Points: Rewards for Healthy Living



Well onTarget understands how hard it can be to maintain a healthy lifestyle. Sometimes you may need a little motivation. That's why we offer Life Points[1] to keep you climbing toward your wellness goals.

With the Life Points program, you will be able to earn points by regularly participating in a range of healthy activities. You can then redeem your points for popular health and wellness merchandise and services.

Rewarding Healthy Behavior

Sample activities that help you earn Life Points include:

- Completing the onmyway™[2] Health Assessment (once every six months)
- Taking all 12 lessons of the onmytime Self-Directed Courses
- Tracking progress in the online tools on the Liveon Member Wellness Portal
- Signing up for the Fitness Program[3]
- Adding weekly Fitness Program visits to your routine
- Achieving Self-directed Course milestones: Baseline, 30 days, 60 days, 90 days, 180 days

Life Points and Well onTarget feature convenient online tools and personalized services that help support, inform and motivate you on a journey to wellness.

Onlife Health is an independent company that provides wellness services for the Well onTarget program.

1 Life Points Program Rules are subject to change without prior notice. See the Program Rules on the Liveon Member Wellness Portal for further information. Your company may have additional reward programs in place to encourage you to take advantage of certain preventive care and wellness activities or for making healthy changes. Check your employee benefits.

2 onmyway is a registered mark of Onlife Health.

3 Healthways, Inc. is an independent contractor which administers the Prime Network of fitness centers. The Prime Network is made up of independently-owned and managed fitness centers.

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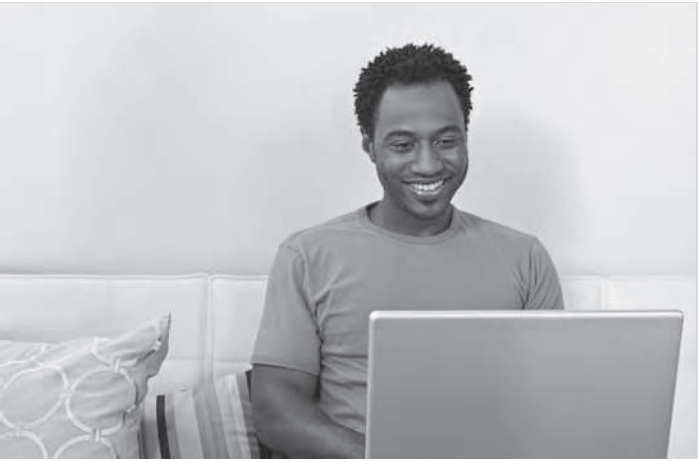
Enhanced Member Experience



The Liveon Member Wellness Portal gives you access to all the interactive tools and programs you need to start racking up Life Points. Check out the online Shopping Mall with an expanded array of rewards to help motivate you to earn more points.

Life Points offers you many new features:

Instant recognition of points
Real-time granting of points[4] gives you with instant notice of your healthy efforts.

Easily manage your points
The interactive portal makes it easier to understand how many points are available to be earned. You can also track the total number of points earned year-to-date. All of your point data will be displayed on one screen.

Get more Life Points
The Life Points program gives you the option to purchase more points to supplement your balance to redeem a larger reward.

Expanded selection of rewards
Redeem your hard-earned points in an expanded online Shopping Mall. Reward categories include Apparel, Books, Health & Personal Care, Jewelry, Electronics, Music and Sporting Goods. In addition, there are more redemption levels so you can earn a reward more quickly.

4 Does not include Life Points earned from the Fitness Program and Biometric Screenings activities.

Health Care Reform

BlueCross BlueShield of Illinois

The Affordable Care Act:

Preventive Services at 100%

Preventive Care Services Covered Without Cost-sharing — Without Copay, Coinsurance or Deductible

The Affordable Care Act requires non-grandfathered health plans and policies to provide coverage for "preventive care services"[1] without cost-sharing (such as coinsurance, deductible or copayment), when the member uses a network provider. Services may include screenings, immunizations, and other types of care, as recommended by the federal government.

Blue Cross and Blue Shield of Illinois (BCBSIL) is committed to implementing coverage changes to meet ACA requirements as well as the needs and expectations of our members.

General Highlights of New Regulations

- Applies to group health plans including insured and self-insured plans, as well as individual and family policies.
- Preventive services are to be covered without any cost-sharing when using a network provider. Cost-sharing can still be required when using a provider that is not in the BCBSIL provider network.
- New requirements can be issued at any time. As new or updated preventive care recommendations or guidelines are issued, employers and insurers have one year to implement the new guidelines unless otherwise specified by the government.[2]
- Plans that cover preventive services in addition to those required may apply cost-sharing requirements for the additional services.
- The regulation references preventive care services with an A or B rating as outlined by the United States Preventive Services Task Force (USPSTF).[1] They are listed in this fact sheet and can be found at: *www.healthcare.gov/news/factsheets/2010/07/preventive-services-list.html*
- BCBSIL will use reasonable medical management techniques to determine any coverage limitations on the service, including the frequency, method, treatment or setting for the service, and the use of an out-of-network provider.

Plans that are **"grandfathered,"** meaning plans that had at least one individual enrolled on March 23, 2010, and have not made certain changes since that date to cause a loss of grandfathered status, are not required to implement some of the new requirements of the Affordable Care Act, including the requirement to cover preventive services with no cost-sharing.

For more information about grandfathered health plans visit this BCBSIL web site: *http://bcbsil.com/affordable_care_act/pdf/bcbsil_fact_sheet_aca_gr_plans.pdf*

Preventive Care Services to Be Offered Without Copay, Coinsurance or Deductible

Evidence-based preventive services: The list of ACA required preventive services includes those that are recommended and rated "A" or "B" by the USPSTF.

Routine vaccinations: A list of immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention are included in the rule. They are considered routine for use with children, adolescents and adults, and range from childhood immunizations to periodic tetanus shots for adults.

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The Affordable Care Act: Preventive Services at 100%

Prevention for children: The rule includes preventive care guidelines for children from birth to age 21 developed by the Health Resources and Services Administration with the American Academy of Pediatrics. Services include regular pediatrician visits, developmental assessments, immunizations, and screening and counseling to address obesity.

Prevention for women: The regulation mandates certain preventive care measures for women. These recommendations will be in place until new requirements for prevention for women are issued by the USPSTF or appear in comprehensive guidelines supported by the Health Resources and Services Administration.[2]

BCBSIL's Focus on Prevention

Laying the groundwork for a healthy tomorrow means disease prevention and early detection.

Many chronic diseases and conditions can be prevented and/or managed through early detection. Preventive screenings are an important way to track your health and avoid chronic conditions before they become more serious.

BCBSIL encourages you to take full advantage of your preventive care benefits and other available wellness resources. After completing a health screening, take appropriate steps to improve your health. Talk with your physician about ways to improve your health. There is no better time than now to get started – and head off potential health problems before they begin.

Billing and Office Visits

- If a recommended preventive service or item is billed separately from an office visit, then cost-sharing may be applied to the office visit.
- If a recommended preventive item or service is not billed separately from an office visit and the primary purpose is preventive care, then cost-sharing requirements may not be imposed with respect to the office visit.
- If a recommended preventive item or service is not billed separately from an office visit and the primary purpose of the office visit is not preventive care, then cost-sharing may be applied to the office visit.

Covered Preventive Care Services[1]

Depending on the particular health plan, coverage may be provided for the following preventive services without cost-sharing.[1] This list may not include all of a particular plan's covered services. BCBSIL members can call Customer Service at the number on their member ID card for details on how these benefits apply to their coverage and the most up-to-date list of covered preventive services, including those paid without any cost-sharing.

Children and Adolescents

Well-child exam

Examples of services included as part of a well-child exam include history and physical exam, measurements of height, weight and body mass index (BMI), hearing screening[4], vision acuity test[5], developmental and behavioral assessments, prescription of fluoride if water source is deficient in fluoride, evaluation of need for a dentist visit, counseling about health risks such as sexually transmitted infections, and obesity counseling.

Immunizations

- Diphtheria, Tetanus, Pertussis
- Haemophilus influenzae type B
- Hepatitis A
- Hepatitis B
- Human Papillomavirus (HPV)
- Influenza (Flu)
- Measles, Mumps, Rubella
- Meningococcal
- Pneumococcal
- Inactivated Poliovirus

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The Affordable Care Act: Preventive Services at 100%

- Rotavirus
- Varicella (Chickenpox)

Screening tests

- Screening for hearing loss, hypothyroidism, sickle cell disease and phenylketonuria (PKU) in newborns
- Hematocrit or hemoglobin screening
- Obesity screening
- Lead screening
- Dyslipidemia screening for children at higher risk of lipid disorder
- Tuberculin testing
- Depression screening
- Screening for sexually transmitted infections (STIs)
- HIV screening
- Cervical dysplasia screening

Preventive treatments

- Gonorrhea preventive medication for eyes of all newborns

Adults

Preventive exam

Examples of services included as part of a preventive exam include history and physical exam, measurements of height, weight and body mass index (BMI).

Immunizations

- Hepatitis A
- Hepatitis B
- Human Papillomavirus (HPV)
- Influenza (Flu)
- Measles, Mumps, Ruebella
- Meningococcal
- Pneumococcal
- Tetanus, Diphtheria, Pertussis
- Varicella (chickenpox)
- Zoster

Screening tests

- Blood pressure screening
- Cholesterol screening
- Colorectal cancer screenings using fecal occult blood testing, sigmoidoscopy or colonoscopy[3]
- Depression screening
- Diabetes screening for adults with high blood pressure
- HIV screening
- Obesity screening
- Sexually transmitted infection (STI) screenings (chlamydia, gonorrhea, syphilis)

Health Counseling

- Alcohol misuse
- Healthy diet
- Obesity
- Prevention of sexually transmitted infections (STIs)
- Tobacco use and cessation
- Use of aspirin to prevent cardiovascular disease
- Use of folic acid

Men Only

- Abdominal Aortic Aneurysm screening

Women Only

- Annual well woman visit
- Breast cancer screening/ Screening mammography
- Cervical cancer screening including Pap smear
- Osteoporosis screening
- Genetic counseling and evaluation for BRCA testing where family history is associated with an increased risk
- Human Papillomavirus (HPV) DNA test
- Counseling related to chemoprevention of breast cancer
- Breastfeeding[9]
- Domestic violence counseling
- Contraception[6]

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The Affordable Care Act: Preventive Services at 100%

Contraception[6]

Depending on your particular health plan, coverage without cost-sharing may expand to include the following contraceptive services when provided by a health care provider in the BCBSIL network.

- Prescription[7] – One or more products within the categories approved by the FDA for use as a method of contraception
- Over-the-counter – Contraceptives available approved by the FDA for women (foam, sponge, female condoms) when prescribed by a physician
- The morning after pill
- Medical devices such as IUD, diaphragm, cervical cap and contraceptive implants
- Female sterilization[8]

For more information about Women's Preventive Services download this BCBSIL Fact Sheet at *http://bcbsil.com/affordable_care_act/pdf/preventative_health_services_women_il.pdf*

Specifically for Pregnant Women

- Alcohol misuse screening and counseling
- Anemia screening
- Bacteriuria screening
- Rh Incompatibility screening
- Gestational diabetes screening
- Hepatitis B screening
- Screenings for Sexually Transmitted Infections (STIs) including chlamydia, gonorrhea, and syphilis
- Tobacco use and cessation counseling

Footnotes

[1] ACA requires non-grandfathered health plans and policies to provide coverage for preventive care services without cost-sharing only when the member uses a network provider. This includes preventive care services with an A or B rating as outlined by the United States Preventive Services Task Force as follows:

- Evidence-based items/services rated A or B in the current recommendations of the U.S. Preventive Services Task Force
- Routine immunizations for children, adolescents and adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease control and prevention
- Evidence-informed preventive care and screenings for infants, children, and adolescents in the comprehensive guidelines of the Health Resources and Services Administrations
- Evidence-based preventive care and screenings for women described in the comprehensive guidelines of the Health Resources and Services Administration

  For a listing of these services visit *http://www.healthcare.gov/news/factsheets/2010/07/preventive-services-list.html*

[2] New requirements can be issued at any time. Plans/policies have one year from issuance to add the new benefit. New requirements on women's preventive services were released by the U.S. Department of Health and Human Services on Aug. 1, 2011. Non-grandfathered plans/policies are required to cover these services beginning with plan/policy years starting on or after Aug. 1, 2012.

[3] Anesthesia also covered as preventive

[4] Further evaluation recommended as a result of a hearing screening test is not considered preventive and may not be covered at 100%.

[5] Vision acuity test to detect amblyopia (lazy eye), strabismus (cross eye), and defects in visual acuity in children younger than age 5 years. Normal vision screening and further evaluation recommended as a result of an acuity test are not considered preventive and may not be covered as preventive.

[6] Under federal guidelines, certain religious employers may not be required to cover contraceptive services. Also, religious-affiliated employers meeting certain criteria may qualify for a temporary enforcement safe harbor period which doesn't require them to cover the recommended contraceptive services for one year.

[7] Prescription coverage for contraception may vary according to the terms and conditions of your health plan's pharmacy benefit. Please call the customer service number on the member ID card for coverage details.

[8] Certain restrictions may apply; there might be copay, coinsurance or deductible in some cases – call the number on your member ID card for more information. Hysterectomies are not considered part of the women's preventive care benefit.

[9] Breastfeeding

- Breastfeeding specialist/nurse practitioner with state-recognized certification who is in your provider network
- Breastfeeding support and counseling by a trained in-network provider while you are pregnant and/or after you've given birth
- Manual breast pump[10]

[10] Electronic and hospital-grade pumps will not be covered with no cost-sharing.

This information is a high-level summary and for general informational purposes only. The information is not comprehensive and does not constitute legal, tax, compliance or other advice or guidance.

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Notice Regarding Your Benefits

This notice is to inform you that for plan years beginning on or after September 23, 2010, Blue Cross and Blue Shield of Illinois (BCBSIL) will administer your benefits in accordance with the terms of your policy and applicable provisions of the Affordable Care Act. BCBSIL will send you an amendment to your policy once it has been approved by the Illinois Department of Insurance.

If you have questions, please contact the customer service number on the back of your identification card.

The HMOs of Blue Cross and Blue Shield of Illinois
BlueAdvantage HMO
300 East Randolph, Chicago, IL 60601 ● Member Services: (800) 892-2803 ● *www.bcbsil.com*

2013 Description of Coverage

Cicero Public School Dist #99
B56722 0000 /8888

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

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

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

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

320 West Washington Street
Springfield, IL 62767-0001

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

You may also contact the department online at http://www.idfpr.com.

(Please be aware that the Office of Consumer Health Insurance will not be able to provide specific plan information. For this type of information you should contact your health care plan directly.)

BlueCross BlueShield
of Illinois

Basics		Description of Coverage
Your Doctor		Choose a medical group and primary care physician (PCP) for each member of your family from our directory or Web site. Each female member may select a Woman's Principal Health Care Provider (WPHCP) in addition to her PCP. A member's PCP and WPHCP must have a referral arrangement with each other. **All care must be provided or coordinated by your PCP, WPHCP or medical group/Independent Practice Association (IPA).**
Annual Deductible		none
Out-of-Pocket Maximum (excludes drugs, vision, durable medical equipment and prosthetics)	Individual	$1,500/calendar year
	Family	$3,000/calendar year
Lifetime Maximums		none
Pre-existing Condition Limitations		none

In the Hospital	Description of Coverage	Health Care Plan Covers	You Pay
Number of Days of Inpatient Care	unlimited days	n/a	n/a
Room & Board	private or semi-private room	100%*	$250 per admission
Surgeon's Fees	covered	100%*	$0
Doctor's Visits	covered	100%*	$0
Medications	covered	100%*	$0
Other Miscellaneous Charges	see exclusions	100%*	$0
Emergency Care			
Emergency Services (medical conditions with acute symptoms of sufficient severity such that a prudent layperson could reasonably expect the absence of medical attention to result in serious jeopardy of the person's health, serious impairment to bodily functions or serious dysfunction to any bodily organ or part)	covered services performed in a hospital emergency room in or out of area. Copay, if any, waived if admitted.	100%	$75
Emergency Post-stabilization Services covered if approved by PCP	primary care physician	100%*	$15
	specialist	100%*	$25

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

In the Doctor's Office		Description of Coverage	Health Care Plan Covers	You Pay
Doctor's Office Visit (copayment covers the visit and all covered services provided)		primary care physician	100%*	$15
		specialist	100%*	$25
Routine Physical Exams		covered	100%*	$15
Diagnostic Tests and X-rays		covered	100%*	$0
Immunizations		covered	100%*	$0
Allergy Treatment & Testing		covered	100%*	$0
Wellness Care		covered	100%*	$15
Medical Services				
Outpatient Surgery		hospital facility	100%*	$0
		physician(s)	100%*	$0
Maternity Care	Hospital Care	unlimited days	100%*	$250 per admission
	Physician Care	copay, if any, for 1st visit only	100%*	$15
Infertility Services		based on your group policy	100%* if covered	$25
Non-Serious Mental Health	Outpatient	unlimited visits	100%*	$15
	Inpatient	unlimited days	100%*	$250 per admission
Substance Abuse/ Chemical Dependency	Outpatient	unlimited visits	100%*	$15
	Inpatient	unlimited days	100%*	$250 per admission
Serious Mental Health	Outpatient	unlimited visits	100%*	$15
	Inpatient	unlimited days	100%*	$250 per admission
Outpatient Rehabilitation Services (includes, but is not limited to, physical, occupational or speech therapy)		60 visits combined/CY	100%*	$15
Outpatient Speech Therapy (for Pervasive Developmental Disorder only)		20 visits/CY	100%*	$15

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

Other Services		Description of Coverage	Health Care Plan Covers	You Pay
Durable Medical Equipment		covered	100%*	$0
Prosthetic Devices		covered	100%*	$0
Ambulance Service		covered	100%*	$0
Hospice		covered	100%*	$0
Coordinated Home Care (excludes custodial care)		covered	100%*	$0
Prescription Drug – up to 34 day supply per script	Generic	covered	100%*	$10
	Formulary Brand	covered	100%*	$40
	Non-formulary Brand	covered	100%*	$60
	Self-injectable	covered	100%*	$50
Prescription Drug – ▫ up to 90 day supply per script ▫ visit *www.bcbsil.com* or call Member Services for information on the 90 day pharmacy network	Generic	covered	100%*	$20
	Formulary Brand	covered	100%*	$80
	Non-formulary Brand	covered	100%*	$120
	Self-injectable	covered	100%*	$50
Dental Services		see limitations, pages 6-7	100%*	$25
Vision Care	Exams	one every 12 months	100%*	$15
	Eyewear	based on your group policy	0%	remainder after discount

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

Service Area

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

Exclusions and Limitations

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

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

Exclusions

1. Services or supplies that are not specifically listed in *Your Health Care Benefit Program Certificate*.
2. Services or supplies that were not ordered by your primary care physician or Woman's Principal Health Care Provider, except as explained in the *Certificate*.
3. Services or supplies received before your coverage began or after the date your coverage ended.
4. Services or supplies for which benefits have been paid under any Workers' Compensation Law or other similar laws.
5. Services or supplies that are furnished to you by the local, state or federal government and services or supplies to the extent payments or benefits for such services are provided by or available from the local, state or federal government (for example, Medicare) whether or not those payments or benefits are received; except, however, this exclusion shall not be applicable to medical assistance benefits under Article V, VI or VII of the Illinois Public Aid Code or similar legislation of any state, benefits provided in compliance with the Tax Equity and Fiscal Responsibility Act or as otherwise provided by law.
6. Services or supplies rendered to you as the result of an injury caused by another person to the extent that you have collected damages for such injury and that the Plan has provided benefits for the services or supplies rendered in connection with such injury.
7. Services or supplies that do not meet accepted standards of medical or dental practice including, but not limited to, services which are investigational in nature.
8. Custodial care services.
9. Long Term Care services.
10. Respite Care Services, except as specifically mentioned under Hospice Care Benefits.
11. Services or supplies rendered because of behavioral, social maladjustment, lack of discipline or other antisocial actions, which are not specifically the result of mental illness.
12. Special education therapy, such as music therapy or recreational therapy.
13. Cosmetic surgery and related services and supplies unless correcting congenital deformities or conditions resulting from accidental injuries, tumors or disease.
14. Services or supplies received from a dental or medical department or clinic maintained by an employer, labor union or other similar person or group.
15. Services or supplies for which you are not required to make payment or would have no legal obligation to pay if you did not have this or similar coverage.
16. Charges for failure to keep a scheduled visit or for completion of a claim form or charges for transferring medical records.

17. Personal hygiene, comfort or convenience items commonly used for purposes that are not medical in nature, such as air conditioners, humidifiers, physical fitness equipment, televisions or telephones.
18. Special braces, splints, specialized equipment, appliances, ambulatory apparatus or battery controlled implants.
19. Prosthetic devices, special appliances or surgical implants unrelated to the treatment of disease or injury, for cosmetic purposes or for the comfort of the patient.
20. Nutritional items such as infant formula, weight-loss supplements, over-the-counter food substitutes and non-prescription vitamins and herbal supplements.
21. Blood derivatives which are not classified as drugs in the official formularies.
22. Marriage counseling.
23. Hypnotism.
24. Inpatient and Outpatient Private-Duty Nursing Service.
25. Routine foot care, except for persons diagnosed with diabetes.
26. Maintenance occupational therapy, maintenance physical therapy, and maintenance speech therapy.
27. Maintenance care.
28. Self-management training, education and medical nutrition therapy.
29. Services or supplies which are rendered for the care, treatment, filling, removal, replacement or artificial restoration of the teeth or structures directly supporting the teeth.
30. Treatment of temporomandibular joint syndrome with intraoral prosthetic devices or any other method which alters vertical dimension or treatment of temporomandibular joint dysfunction not caused by documented organic joint disease or physical trauma.
31. Services or supplies rendered for human organ or tissue transplants, except as stated in the *Certificate*.
32. Hearing aids, except as stated in the Certificate.
33. Wigs (also referred to as cranial protheses).

Limitations

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

1. Benefits for oral surgery are limited to:
   - surgical removal of completely bony impacted teeth,
   - excision of tumors or cysts from the jaws, cheeks, lips, tongue, roof or floor of the mouth,
   - surgical procedures to correct accidental injuries of the jaws, cheeks, lips, tongue, roof or floor of the mouth,
   - excision of exostoses of the jaws and hard palate (provided that this procedure is not done in preparation for dentures or other prostheses),
   - treatment of fractures of the facial bone,
   - external incision and drainage of cellulitis,
   - incision of accessory sinuses, salivary glands or ducts, and
   - reduction of, dislocation of or excision of the temporomandibular joints.
2. Benefits for treatment of dental injury due to accident are limited to treatment of sound natural teeth.
3. Benefits for outpatient rehabilitative therapy are limited to therapy which is expected to result in significant improvement within two months in the condition for which it is rendered.
4. Family planning benefits are not available for repeating or reversing sterilization.
5. Benefits for elective abortion are limited to two per lifetime and are not covered under all benefit plans.
6. Benefits for infertility, when covered, will not be provided for the following:
   - Reversal of voluntary sterilization. However, in the event a voluntary sterilization is successfully reversed, benefits will be provided if your diagnosis meets the definition of "infertility",
   - Services or supplies rendered to a surrogate, except those costs for procedures to obtain eggs, sperm or

embryos from you, will be covered if you choose to use a surrogate,

- selected termination of an embryo in cases where the mother's life is not in danger,
- cryo-preservation or storage of sperm, eggs or embryos, except for those procedures which use a cryo-preserved substance
- non-medical costs of an egg or sperm donor,
- travel costs for travel within 100 miles of the covered person's home or which is not medically necessary or which is not required by the plan,
- infertility treatments which are determined to be investigational, in writing, by the American Society for Reproductive Medicine or American College of Obstetrics and Gynecology, and
- Infertility treatment rendered to your dependents under the age of 18.

7. Benefits for ambulance service are limited to certified ground ambulance, except for human organ transplants.
8. Human organ transplants must be performed at a plan-approved center for human organ transplants and benefits do not include organ transplants and/or services or supplies rendered in connection with an organ transplant which are investigational as determined by the appropriate technological body; drugs which are investigational; storage fees; services provided to any individual who is not the recipient or actual donor, unless otherwise specified in this provision; cardiac rehabilitation services when not provided to the transplant recipient immediately following discharge from a hospital for transplant surgery; or travel time or related expenses incurred by a provider.
9. Hospice benefits are only available for persons having a life expectancy of one year or less.
10. Prescription drug benefits, when covered, do not include drugs used for cosmetic purposes; any devices or appliances; any charges incurred for administration of drugs; or refills if the prescription is more than one year old.
11. Vision exams are limited to one per 12 month period. Vision coverage does not include benefits for:
    - recreational sunglasses
    - orthoptics, vision training, subnormal vision aids, aniseikonic lenses or tonography
    - additional charges for tinted, photo-sensitive or anti-reflective lenses beyond the benefit allowance for regular lenses
    - replacement of lenses, frames or contact lenses, which are lost or broken unless such lenses, frames or contact lenses would otherwise be covered according to the benefit period limitations
12. Durable Medical Equipment rental is covered up to the price of purchase.
13. Mental health and chemical dependency treatment benefits may be limited – see your *Certificate*.
14. Rehabilitation therapy benefits may be limited – see your *Certificate*.
15. Maternity inpatient hospital benefits are limited to 48 hours after birth for vaginal deliveries and 96 hours after birth for cesarean deliveries, unless a longer stay is medically necessary.

Pre-certification and Utilization Review

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

Primary Care Physician (PCP) Selection

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

Access to Specialty Care

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

Out-of-Area Coverage

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

Financial Responsibility

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

Continuity of Treatment (Transition of Care)

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

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

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

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

Submit the request to:

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

Include the following information:

- Policyholder's name and work/home phone numbers
- Group and ID numbers

- Chosen medical group site
- Chosen PCP name, address and phone/fax numbers
- Current treating physician
- Clinical diagnosis
- Presenting clinical condition (if applicable)
- Reason for transition of care request
- Expected effective date with the HMO or new medical group/IPA (if applicable)

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

Appeals Process

You can file an appeal by writing to the HMO or calling Member Services.

Non-urgent Clinical Appeal

After the appeal is received, the HMO Level II Appeal Committee will request any additional information needed to evaluate your appeal and make a decision about your appeal within 15 days after receiving the required information.

You will be informed in advance that you, or someone representing you, have the right to appear before the Committee either in person, via conference call or some other method. You will also receive a verbal notification of the HMO's decision. A written notification will be sent within five business days of the appeal determination. Your representative (if any), your PCP and any other health care provider involved in the matter will receive the same verbal and written notices.

Urgent Clinical Appeal

After the appeal is received, the HMO Level II Appeal Committee will request any additional information needed to evaluate your appeal and make a decision about your appeal and notify you by phone within 24 hours – or no later than three calendar days – of the initial receipt of the clinical appeal request. You will be informed in advance that you, or someone representing you, have the right to appear before the Committee either in person, via conference call or some other method. You will also receive a verbal notification of the HMO's decision. A written notification will be sent within two business days of the appeal determination. Your representative (if any), your PCP and any other health care provider involved in the matter will receive the same verbal and written notices.

Non-clinical Appeal

A non-clinical appeal concerns an adverse decision of an inquiry, complaint or action by the HMO, its employees or its independent contractors that has not been resolved to your satisfaction. A non-clinical appeal relates to administrative health care services that include (but are not limited to) membership, access, claim payment, denial of benefits, out-of-area benefits and coordination of benefits with another health carrier.

To begin a Level I appeal, notify Member Services by telephone or in writing that you want to pursue a non-clinical appeal. The HMO will send you a written confirmation within five business days of receiving your request. If your appeal can be resolved with existing information, the HMO will inform you of its decision within 30 business days.

If additional information is needed from either you or your medical group/IPA, the HMO will request that it be provided within five business days. The appeal decision will be made within 30 business days. When the decision cannot be made within 30 business days, due to circumstances beyond the HMO's control, the HMO will inform you in writing of the delay. A decision will be made on or before the 45th business day of receiving the appeal.

If the appeal is denied, you will be notified that your case is being referred to a Level II review. You or a representative has the right to appear in person, via conference call or some other method. After receiving your Level II appeal, the HMO will notify you in writing at least five business days before the Level II Appeals Committee meets. You will receive the Committee's decision in writing within five business days of the meeting and within 30 business days of beginning the Level II appeal process.

ANY ENROLLEE NOT SATISFIED WITH THE PLAN'S RESOLUTION OF ANY CLINICAL APPEAL, APPEAL OR COMPLAINT MAY APPEAL THE FINAL PLAN DECISION TO THE DIVISION OF INSURANCE, CONSUMER SERVICES SECTION, THROUGH ONE OF THE FOLLOWING LOCATIONS:

- **100 West Randolph Street, Suite 15-100 Chicago, IL 60601-3251**
- **320 West Washington Street, Springfield, IL 62767-0001**

You may also contact the Division of Insurance by phone or online at:

- **(877) 527-9431**
- **http://www.idfpr.com.**

IMPORTANT: External review determinations might not be appealable through the Division of Insurance.

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

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

To receive a Description of Coverage specific to your benefits, call **(800) 892-2803** or return the enclosed pre-paid card.

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

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

The HMOs of Blue Cross and Blue Shield of Illinois
HMO Illinois
300 East Randolph, Chicago, IL 60601 ● Member Services: (800) 892-2803 ● *www.bcbsil.com*

2013 Description of Coverage

Cicero Public School Dist #99
H56722 0000 / 8888

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

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

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

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

320 West Washington Street
Springfield, IL 62767-0001

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

You may also contact the department online at http://www.idfpr.com.

(Please be aware that the Office of Consumer Health Insurance will not be able to provide specific plan information. For this type of information you should contact your health care plan directly.)

BlueCross BlueShield of Illinois

Basics		Description of Coverage
Your Doctor		Choose a medical group and primary care physician (PCP) for each member of your family from our directory or Web site. Each female member may select a Woman's Principal Health Care Provider (WPHCP) in addition to her PCP. A member's PCP and WPHCP must have a referral arrangement with each other. **All care must be provided or coordinated by your PCP, WPHCP or medical group/Independent Practice Association (IPA).**
Annual Deductible		none
Out-of-Pocket Maximum (excludes drugs, vision, durable medical equipment and prosthetics)	Individual	$1500/calendar year
	Family	$3000/calendar year
Lifetime Maximums		none
Pre-existing Condition Limitations		none

In the Hospital	Description of Coverage	Health Care Plan Covers	You Pay
Number of Days of Inpatient Care	unlimited days	n/a	n/a
Room & Board	private or semi-private room	100%*	$250 copay per admission
Surgeon's Fees	covered	100%*	$0
Doctor's Visits	covered	100%*	$0
Medications	covered	100%*	$0
Other Miscellaneous Charges	see exclusions	100%*	$0
Emergency Care			
Emergency Services (medical conditions with acute symptoms of sufficient severity such that a prudent layperson could reasonably expect the absence of medical attention to result in serious jeopardy of the person's health, serious impairment to bodily functions or serious dysfunction to any bodily organ or part)	covered services performed in a hospital emergency room in or out of area. Copay, if any, waived if admitted.	100%	$100
Emergency Post-stabilization Services covered if approved by PCP	primary care physician	100%*	$20
	specialist	100%*	$30

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

In the Doctor's Office		Description of Coverage	Health Care Plan Covers	You Pay
Doctor's Office Visit (copayment covers the visit and all covered services provided)		primary care physician	100%*	$20
		specialist	100%*	$30
Routine Physical Exams		covered	100%*	$20
Diagnostic Tests and X-rays		covered	100%*	$0
Immunizations		covered	100%*	$0
Allergy Treatment & Testing		covered	100%*	$0
Wellness Care		covered	100%*	$20
Medical Services				
Outpatient Surgery		hospital facility	100%*	$0
		physician(s)	100%*	$0
Maternity Care	Hospital Care	unlimited days	100%*	$250 copay per admission
	Physician Care	copay, if any, for 1st visit only	100%*	$20
Infertility Services		based on your group policy	100%* if covered	$30
Non-Serious Mental Health	Outpatient	unlimited visits	100%*	$20
	Inpatient	unlimited days	100%*	$250 copay per admission
Substance Abuse/ Chemical Dependency	Outpatient	unlimited visits	100%*	$20
	Inpatient	unlimited days	100%*	$250 copay per admission
Serious Mental Health	Outpatient	unlimited visits	100%*	$20
	Inpatient	unlimited days	100%*	$250 copay per admission
Outpatient Rehabilitation Services (includes, but is not limited to, physical, occupational or speech therapy)		60 visits combined/CY	100%*	$20
Outpatient Speech Therapy (for Pervasive Developmental Disorder only)		20 visits/CY	100%*	$20

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

Other Services		Description of Coverage	Health Care Plan Covers	You Pay
Durable Medical Equipment		covered	100%*	$0
Prosthetic Devices		covered	100%*	$0
Ambulance Service		covered	100%*	$0
Hospice		covered	100%*	$0
Coordinated Home Care (excludes custodial care)		covered	100%*	$0
Prescription Drug – up to 34 day supply per script	Generic	covered	100%*	$10
	Formulary Brand	covered	100%*	$40
	Non-formulary Brand	covered	100%*	$60
	Self-injectable	covered	100%*	$50
Prescription Drug – ▫ up to 90 day supply per script ▫ visit *www.bcbsil.com* or call Member Services for information on the 90 day pharmacy network	Generic	covered	100%*	$20
	Formulary Brand	covered	100%*	$80
	Non-formulary Brand	covered	100%*	$120
	Self-injectable	covered	100%*	$50
Dental Services		see limitations, pages 6-7	100%*	$30
Vision Care	Exams	one every 12 months	100%*	$20
	Eyewear	based on your group policy	0%	remainder after discount

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

Service Area

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

Exclusions and Limitations

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

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

Exclusions

1. Services or supplies that are not specifically listed in *Your Health Care Benefit Program Certificate*.
2. Services or supplies that were not ordered by your primary care physician or Woman's Principal Health Care Provider, except as explained in the *Certificate*.
3. Services or supplies received before your coverage began or after the date your coverage ended.
4. Services or supplies for which benefits have been paid under any Workers' Compensation Law or other similar laws.
5. Services or supplies that are furnished to you by the local, state or federal government and services or supplies to the extent payments or benefits for such services are provided by or available from the local, state or federal government (for example, Medicare) whether or not those payments or benefits are received; except, however, this exclusion shall not be applicable to medical assistance benefits under Article V, VI or VII of the Illinois Public Aid Code or similar legislation of any state, benefits provided in compliance with the Tax Equity and Fiscal Responsibility Act or as otherwise provided by law.
6. Services or supplies rendered to you as the result of an injury caused by another person to the extent that you have collected damages for such injury and that the Plan has provided benefits for the services or supplies rendered in connection with such injury.
7. Services or supplies that do not meet accepted standards of medical or dental practice including, but not limited to, services which are investigational in nature.
8. Custodial care services.
9. Long Term Care services.
10. Respite Care Services, except as specifically mentioned under Hospice Care Benefits.
11. Services or supplies rendered because of behavioral, social maladjustment, lack of discipline or other antisocial actions, which are not specifically the result of mental illness.
12. Special education therapy, such as music therapy or recreational therapy.
13. Cosmetic surgery and related services and supplies unless correcting congenital deformities or conditions resulting from accidental injuries, tumors or disease.
14. Services or supplies received from a dental or medical department or clinic maintained by an employer, labor union or other similar person or group.
15. Services or supplies for which you are not required to make payment or would have no legal obligation to pay if you did not have this or similar coverage.
16. Charges for failure to keep a scheduled visit or for completion of a claim form or charges for transferring medical records.

17. Personal hygiene, comfort or convenience items commonly used for purposes that are not medical in nature, such as air conditioners, humidifiers, physical fitness equipment, televisions or telephones.
18. Special braces, splints, specialized equipment, appliances, ambulatory apparatus or battery controlled implants.
19. Prosthetic devices, special appliances or surgical implants unrelated to the treatment of disease or injury, for cosmetic purposes or for the comfort of the patient.
20. Nutritional items such as infant formula, weight-loss supplements, over-the-counter food substitutes and non-prescription vitamins and herbal supplements.
21. Blood derivatives which are not classified as drugs in the official formularies.
22. Marriage counseling.
23. Hypnotism.
24. Inpatient and Outpatient Private-Duty Nursing Service.
25. Routine foot care, except for persons diagnosed with diabetes.
26. Maintenance occupational therapy, maintenance physical therapy, and maintenance speech therapy.
27. Maintenance care.
28. Self-management training, education and medical nutrition therapy.
29. Services or supplies which are rendered for the care, treatment, filling, removal, replacement or artificial restoration of the teeth or structures directly supporting the teeth.
30. Treatment of temporomandibular joint syndrome with intraoral prosthetic devices or any other method which alters vertical dimension or treatment of temporomandibular joint dysfunction not caused by documented organic joint disease or physical trauma.
31. Services or supplies rendered for human organ or tissue transplants, except as stated in the *Certificate*.
32. Hearing aids, except as stated in the Certificate.
33. Wigs (also referred to as cranial protheses).

Limitations

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

1. Benefits for oral surgery are limited to:
   - surgical removal of completely bony impacted teeth,
   - excision of tumors or cysts from the jaws, cheeks, lips, tongue, roof or floor of the mouth,
   - surgical procedures to correct accidental injuries of the jaws, cheeks, lips, tongue, roof or floor of the mouth,
   - excision of exostoses of the jaws and hard palate (provided that this procedure is not done in preparation for dentures or other prostheses),
   - treatment of fractures of the facial bone,
   - external incision and drainage of cellulitis,
   - incision of accessory sinuses, salivary glands or ducts, and
   - reduction of, dislocation of or excision of the temporomandibular joints.
2. Benefits for treatment of dental injury due to accident are limited to treatment of sound natural teeth.
3. Benefits for outpatient rehabilitative therapy are limited to therapy which is expected to result in significant improvement within two months in the condition for which it is rendered.
4. Family planning benefits are not available for repeating or reversing sterilization.
5. Benefits for elective abortion are limited to two per lifetime and are not covered under all benefit plans.
6. Benefits for infertility, when covered, will not be provided for the following:
   - Reversal of voluntary sterilization. However, in the event a voluntary sterilization is successfully reversed, benefits will be provided if your diagnosis meets the definition of "infertility",
   - Services or supplies rendered to a surrogate, except those costs for procedures to obtain eggs, sperm or

embryos from you, will be covered if you choose to use a surrogate,

- selected termination of an embryo in cases where the mother's life is not in danger,
- cryo-preservation or storage of sperm, eggs or embryos, except for those procedures which use a cryo-preserved substance
- non-medical costs of an egg or sperm donor,
- travel costs for travel within 100 miles of the covered person's home or which is not medically necessary or which is not required by the plan,
- infertility treatments which are determined to be investigational, in writing, by the American Society for Reproductive Medicine or American College of Obstetrics and Gynecology, and
- Infertility treatment rendered to your dependents under the age of 18.

7. Benefits for ambulance service are limited to certified ground ambulance, except for human organ transplants.
8. Human organ transplants must be performed at a plan-approved center for human organ transplants and benefits do not include organ transplants and/or services or supplies rendered in connection with an organ transplant which are investigational as determined by the appropriate technological body; drugs which are investigational; storage fees; services provided to any individual who is not the recipient or actual donor, unless otherwise specified in this provision; cardiac rehabilitation services when not provided to the transplant recipient immediately following discharge from a hospital for transplant surgery; or travel time or related expenses incurred by a provider.
9. Hospice benefits are only available for persons having a life expectancy of one year or less.
10. Prescription drug benefits, when covered, do not include drugs used for cosmetic purposes; any devices or appliances; any charges incurred for administration of drugs; or refills if the prescription is more than one year old.
11. Vision exams are limited to one per 12 month period. Vision coverage does not include benefits for:
    - recreational sunglasses
    - orthoptics, vision training, subnormal vision aids, aniseikonic lenses or tonography
    - additional charges for tinted, photo-sensitive or anti-reflective lenses beyond the benefit allowance for regular lenses
    - replacement of lenses, frames or contact lenses, which are lost or broken unless such lenses, frames or contact lenses would otherwise be covered according to the benefit period limitations
12. Durable Medical Equipment rental is covered up to the price of purchase.
13. Mental health and chemical dependency treatment benefits may be limited – see your *Certificate*.
14. Rehabilitation therapy benefits may be limited – see your *Certificate*.
15. Maternity inpatient hospital benefits are limited to 48 hours after birth for vaginal deliveries and 96 hours after birth for cesarean deliveries, unless a longer stay is medically necessary.

Pre-certification and Utilization Review

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

Primary Care Physician (PCP) Selection

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

Access to Specialty Care

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

Out-of-Area Coverage

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

Financial Responsibility

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

Continuity of Treatment (Transition of Care)

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

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

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

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

Submit the request to:

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

Include the following information:

- Policyholder's name and work/home phone numbers
- Group and ID numbers

- Chosen medical group site
- Chosen PCP name, address and phone/fax numbers
- Current treating physician
- Clinical diagnosis
- Presenting clinical condition (if applicable)
- Reason for transition of care request
- Expected effective date with the HMO or new medical group/IPA (if applicable)

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

Appeals Process

You can file an appeal by writing to the HMO or calling Member Services.

Non-urgent Clinical Appeal

After the appeal is received, the HMO Level II Appeal Committee will request any additional information needed to evaluate your appeal and make a decision about your appeal within 15 days after receiving the required information.

You will be informed in advance that you, or someone representing you, have the right to appear before the Committee either in person, via conference call or some other method. You will also receive a verbal notification of the HMO's decision. A written notification will be sent within five business days of the appeal determination. Your representative (if any), your PCP and any other health care provider involved in the matter will receive the same verbal and written notices.

Urgent Clinical Appeal

After the appeal is received, the HMO Level II Appeal Committee will request any additional information needed to evaluate your appeal and make a decision about your appeal and notify you by phone within 24 hours – or no later than three calendar days – of the initial receipt of the clinical appeal request. You will be informed in advance that you, or someone representing you, have the right to appear before the Committee either in person, via conference call or some other method. You will also receive a verbal notification of the HMO's decision. A written notification will be sent within two business days of the appeal determination. Your representative (if any), your PCP and any other health care provider involved in the matter will receive the same verbal and written notices.

Non-clinical Appeal

A non-clinical appeal concerns an adverse decision of an inquiry, complaint or action by the HMO, its employees or its independent contractors that has not been resolved to your satisfaction. A non-clinical appeal relates to administrative health care services that include (but are not limited to) membership, access, claim payment, denial of benefits, out-of-area benefits and coordination of benefits with another health carrier.

To begin a Level I appeal, notify Member Services by telephone or in writing that you want to pursue a non-clinical appeal. The HMO will send you a written confirmation within five business days of receiving your request. If your appeal can be resolved with existing information, the HMO will inform you of its decision within 30 business days.

If additional information is needed from either you or your medical group/IPA, the HMO will request that it be provided within five business days. The appeal decision will be made within 30 business days. When the decision cannot be made within 30 business days, due to circumstances beyond the HMO's control, the HMO will inform you in writing of the delay. A decision will be made on or before the 45th business day of receiving the appeal.

If the appeal is denied, you will be notified that your case is being referred to a Level II review. You or a representative has the right to appear in person, via conference call or some other method. After receiving your Level II appeal, the HMO will notify you in writing at least five business days before the Level II Appeals Committee meets. You will receive the Committee's decision in writing within five business days of the meeting and within 30 business days of beginning the Level II appeal process.

ANY ENROLLEE NOT SATISFIED WITH THE PLAN'S RESOLUTION OF ANY CLINICAL APPEAL, APPEAL OR COMPLAINT MAY APPEAL THE FINAL PLAN DECISION TO THE DIVISION OF INSURANCE, CONSUMER SERVICES SECTION, THROUGH ONE OF THE FOLLOWING LOCATIONS:

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- **320 West Washington Street, Springfield, IL 62767-0001**

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- **(877) 527-9431**
- **http://www.idfpr.com.**

IMPORTANT: External review determinations might not be appealable through the Division of Insurance.

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

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

To receive a Description of Coverage specific to your benefits, call **(800) 892-2803** or return the enclosed pre-paid card.

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

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

Participating Provider Option PPO

BlueCross BlueShield of Illinois

CICERO PUBLIC SCHOOL DISTRICT #99

BENEFIT HIGHLIGHTS

PPO Network

This provides only highlights of the benefit plan. After enrollment, members will receive a Certificate that more fully describes the terms of coverage.

Program Basics	PPO (In-Network)	Non-PPO (Out-of-Network)
Lifetime Benefit Maximum		
Per individual	UNLIMITED	
Individual Coverage Deductible		
Program deductible does **not** apply to services that have a copayment.	$300	$600
Family Coverage Deductible		
The family deductible maximum is equal to three individual deductibles.	$900	$1,800
Individual Coverage Out-of-Pocket Expense (OPX) Limit		
The amount of money that any individual will have to pay toward covered health care expenses during any one calendar year. The following items will **not** be applied to the out-of-pocket expense limit: • **Deductibles** • **Copayments** • **Reductions in benefits** due to non-compliance with utilization management program requirements • **Charges that exceed the eligible charge** or the Schedule of Maximum Allowances (SMA) • **Services that are asterisked below** (*)	$950	$1,760
Family Coverage Out-of-Pocket Expense (OPX) Limit		
	$2,850	$5,280
Prescription Drug Card (Retail and Mail Service)		
Please refer to the *Outpatient Prescription Drug Highlights Sheet* for the covered benefits.		
Physician Services		
Physician Office Visits		
One copayment per day when you receive services from a Family Practice, Internal Medicine, OB/GYN, or Pediatrician. Surgeries, therapies and certain diagnostic procedures performed in a physician's office may be subject to the deductible and/or coinsurance, including mental health and substance abuse services.	$20 copay, then 100%	70% after deductible
One copayment per day when you receive services from a specialist. Surgeries, therapies and certain diagnostic procedures performed in a physician's office may be subject to the deductible and/or coinsurance.	$30 copay, then 100%	70% after deductible
Well Care (all ages)		
Includes benefits for routine physical examinations, immunizations and routine diagnostic tests. • Limited to one physical exam plus one gynecological exam per calendar year.	$20 copay, then 100%	70% after deductible
Maternity Services		
Copayment applies to first prenatal visit (per pregnancy). All other maternity physician covered services are paid the same as Medical / Surgical Services.	$20 copay, then 100%	70% after deductible
Medical / Surgical Services		
Coverage for surgical procedures, inpatient visits, therapies, allergy injections or treatments, and certain diagnostic procedures as well as other physician services.	90% after deductible	70% after deductible
Hospital Services		
Hospital Admission Deductible		
Per admission, per individual	N/A	$250*
Inpatient Hospital Services		
Coverage includes services received in a hospital, skilled nursing facility, coordinated home care and hospice, including mental health and substance abuse services. Room allowances based on the hospital's most common semi-private room rates.	90% after deductible	70% after deductible
Outpatient Hospital Services		
Coverage for services includes, but is not limited to outpatient or ambulatory surgical procedures, x-ray, lab tests, chemotherapy, radiation therapy, renal dialysis, and mammograms performed in a hospital or ambulatory surgical center, including mental health and substance abuse services. Routine mammograms performed in an in-network outpatient hospital setting are payable at 100%, no deductible will apply.	90% after deductible	70% after deductible
Outpatient Emergency Care (Accident or Illness)		
The copayment applies to both in- and out-of-network emergency room visits. The copayment is waived if the member is admitted to the hospital.	80%, no deductible	

BlueCross BlueShield of Illinois

BENEFIT HIGHLIGHTS

PPO Network

Additional Services

Muscle Manipulation Services*		
Coverage for spinal and muscle manipulation services provided by a physician or chiropractor. Related office visits are paid the same as other Physician Office Visits. • 20 visits per calendar year.	*90% after deductible*	*70% after deductible*
Therapy Services – Speech, Occupational and Physical		
Coverage for services provided by a physician or therapist. Outpatient -Unlimited for Physical, Occupational 30 Visit Limit, Speech 20 Visit Limit per calendar year)	*90% after deductible*	*70% after deductible*
Temporomandibular Joint (TMJ) Dysfunction and Related Disorders	*90% after deductible*	*70% after deductible*
Other Covered Services • Private duty nursing (50 Visits per calendar year) • Naprapathic services* - $1,000 maximum per calendar year • Blood and blood components • Ambulance services • Medical supplies *See paragraph below regarding Schedule of Maximum Allowances (SMA).*	*80% after deductible*	

* Does not apply to any out-of-pocket limits

Durable Medical Equipment (DME) is a covered benefit. Please refer to Certificate for details.

Optometrists, Orthotic, Prosthetic, Pedorthists, Registered Surgical Assistants, Registered Nurse First Assistants and Registered Surgical Technologists are covered providers. Please refer to Certificate for details.

Discounts on Eye Exams, Prescription Lenses and Eyewear
Members can present their ID cards to receive discounts on eye exams, prescription lenses and eyewear. To locate participating vision providers, log into Blue Access® for Members (BAM) at www.bcbsil.com/member and click on the **BlueExtras Discount Program** link.

Blue Care Connection (BCC)
When members receive covered inpatient hospital services, outpatient mental health and substance abuse services (MHSA), coordinated home care, skilled nursing facility or private duty nursing from a participating provider, the member will be responsible for contacting either the BCC or MHSA preauthorization line, as applicable. You must call one day prior to any hospital admission and/or outpatient MH/SA service or within 2 business days after an emergency medical or maternity admission. Please refer to your benefit booklet for information regarding benefit reductions based on failure to contact the applicable preauthorization line**. Note: Outpatient MHSA preauthorization is effective for services on or after January 1, 2011 or upon your group plan renewal date in 2011 and thereafter.**

Schedule of Maximum Allowances (SMA)
The Schedule of Maximum Allowances (SMA) is not the same as a Usual and Customary fee (U&C). Blue Cross and Blue Shield of Illinois' SMA is the maximum allowable charge for professional services, including but not limited to those listed under Medical/Surgical and Other Covered Services above. The SMA is the amount that professional PPO providers have agreed to accept as payment in full. When members use PPO providers, they avoid any balance billing other than applicable deductible, coinsurance and/or copayment. "*Please refer to your certificate booklet for the definition of Eligible Charge and Maximum Allowance regarding Providers who do not participate in the PPO Network.*".

To Locate a Participating Provider: Visit our Web site at **www.bcbsil.com/providers** and use our Provider Finder® tool.

In addition, benefits for covered individuals who live outside Illinois will meet all extraterritorial requirements of those states, if any, according to the group's funding arrangements.

Prescription Drug Card

BlueCross BlueShield of Illinois

Cicero Public School Dist #99

BENEFIT HIGHLIGHTS

Program Basics	Payment Options (Generic / Preferred Brand / Non-Preferred Brand)
Retail	
Copayments are for up to a 34-day supply at a contracting retail pharmacy, including diabetic supplies: blood glucose test strips, diagnostic agents used with urine testing, glucagon.	*$10/ $40 / $60*
Mail Service	
Maintenance medications are available for up to a 90-day supply and are subject to the appropriate copayment amount, including diabetic supplies: blood glucose test strips, diagnostic agents used with urine testing, glucagon.	*$20/$80/$120*
Contraceptives	
Available at retail and mail service at the appropriate copayment level based on drug classification.	*As indicated above*
Self-Injectables	
Available at retail and mail service at the appropriate copayment level.	*As indicated above*

*effective 1/1/10, members with a BCBSIL drug card will have lancets pay at a $0 copay

Reimbursement for non-contracting pharmacies
Benefits at a non-contracting pharmacy are covered at 75% of the amount that would have been paid at a contracting pharmacy minus the appropriate copayment amount.

Prior Authorization and Step Therapy Program Requirements
Your physician may be required to obtain authorization from BCBSIL in order to receive benefits for certain drugs that have a potential for misuse. Examples of these medications include: rheumatoid arthritis, growth hormone, hepatitis C, and anabolic steroids. In the event prior authorization is not obtained, you will be responsible for the first $1,000 or 50% of the Eligible Charge, whichever is less.

If you are required to receive prior authorization for certain medications under the step therapy program, you need to first try a proven, cost effective medication before progressing to a more costly treatment, if necessary. After a member has a prescription history for a lower-cost alternative medication, coverage will automatically be provided for a more costly medication included in the step therapy program, if the physician and member determine that it is necessary for the member to try a drug included in the program. As an alternative to receiving prior authorization for a drug included in the step therapy program, or paying the entire cost of the drug out-of-pocket, a member along with his/her physician may select another drug, which is not part of the program.

Prescription drugs categories are added to the program and are subject to change periodically. To verify which drugs are included in your prescription drug benefit program, contact the Pharmacy Program customer service number, which is located on the back of your ID card. You can also visit the BCBSIL Web site at *www.bcbsil.com* and log on to **Blue Access® for Members** to find additional information.

What is the Blue Cross and Blue Shield of Illinois formulary?
The BCBSIL formulary is a regularly updated list of preferred drugs determined by our Pharmacy and therapeutic Committee, a national panel comprised of individuals who hold a medical or pharmacy degree who evaluate U.S. Food and Drug Administration (FDA)-approved drugs based on comparative clinical standards, including efficacy, safety, uniqueness and cost-effectiveness. The formulary includes all generic drugs and select group of brand drugs. The BCBSIL formulary is "open," meaning that benefits are payable for drugs that are not on the formulary, but are subject to the highest copayment level.

How can I find out if a drug is on the formulary, and if it is a generic or a brand name drug?
As part of the enrollment literature, members may receive a list of some of the most commonly prescribed formulary drugs. If a particular drug does not appear on the list, members can:

- Refer to the pocket edition of the BCBSIL formulary.
- Visit the BCBSIL Web site at www.bcbsil.com.
- Discuss the most appropriate drug therapy with their physician or pharmacist. Using generic drugs whenever possible will help save money.

How can I find a contracting pharmacy?
Visit our Web site at www.bcbsil.com to find a contracting pharmacy.

Rev. 07 / 2013

Health Care Service Corporation, A Mutual Legal Reserve Company
Fort Dearborn Life Insurance Company, A Stock Life Insurance Company
Notice of Information Practices

This description of the Information Practices of Health Care Service Corporation (HCSC) a Mutual Legal Reserve Company and Fort Dearborn Life Insurance Company (FDL), a Stock Life Insurance Company, (collectively referred to herein as "we," "our" or "us"), is provided to you in accordance with the requirements of the Illinois Insurance Information and Privacy Protection Law.

Collection of Information

In order to properly underwrite and administer your insurance coverage, we must collect a certain amount of necessary and helpful information. The amount and type of information may vary depending on the amount and type of coverage applied for, but in general we will be seeking information about your age, occupation, physical condition and health history.

You are our most important source of information, but we may also collect or verify information by contacting medical professionals and institutions which have provided care to you or members of your family proposed for coverage, employers and business associates, friends and neighbors, and other insurance companies you have applied to. We may collect information by exchanges of correspondence, by phone or by personal contact.

Circumstances of Disclosure

In some circumstances, we may make disclosures of personal or privileged information to third parties without your authorization. Following is a description of the types of persons who may receive such information without your authorization and some of the circumstances that might give rise to such disclosures.

- We might use an unaffiliated organization or person to perform a professional, business or insurance function for us. If, for example, we hired an independent organization to assist in the administration of a group insurance plan of which you are a participant, information relating to your insurance coverage would be disclosed to that organization in order for it to adequately perform its function. This would also be the case with respect to any organization or person, which performs a professional, business or insurance function for us.
- We may disclose information concerning your coverage to our agents and producers in order to provide you with adequate service, including the updating and improvement of your insurance program.
- We may disclose information to other insurance institutions, agents, insurance-support organizations or self-insurers, which is necessary (a) to prevent criminal activity, fraud, material misrepresentation or material non-disclosure in connection with insurance transactions, or (b) for either of us or such company to perform its function in connection with an insurance transaction involving you or a member of your family insured under your coverage. For example, if you are a participant in an HCSC or FDL group insurance plan, and if you, your spouse or dependents are insured under other group plans, the companies involved may be required to share claims information pursuant to coordination of benefits provisions in their respective policies. The object, of course, is to make sure that you receive total benefits from all companies no greater than the cost of health care received.
- We may disclose information to the Illinois Insurance regulatory authority in connection with its regulation of our business.
- We may disclose information to a law enforcement or governmental authority to protect our interest in preventing or prosecuting the perpetration of fraud upon us, or if we reasonably believe that illegal activities have been conducted we will also disclose information when permitted or required by law to do so.
- Various industry and professional organizations conduct scientific and actuarial research studies to learn more about the risk experience of our insureds. Other organizations conduct studies relating to medical research. These studies are purely scientific in nature, never identify individuals in their reports, and always maintain information provided in a highly confidential manner. When asked to provide information to such organizations, we ordinarily will do so because the results of such studies are of benefit to our customers and the public at large. You will not be individually identified in any report that results from the research, and material that we give to the person or organization performing the research will be returned to us or destroyed when it is no longer needed.
- If you are covered under an HCSC and/or FDL group policy, we may disclose information as is reasonably necessary to the group for purposes of administration of the group policy and to permit the group to audit, review and evaluate the performance of HCSC and FDL under the group policy.
- We are sometimes approached by persons or organizations that are interested in the opportunity to market products or services to our customers. When this happens, we may provide some limited information. However, if we want to give information to persons not affiliated with us, we will give you an opportunity to indicate to us that you do want information to be disclosed for this purpose. We will give information to our affiliates so that our customers may be aware of the insurance products and services offered by our affiliates.

Please understand that the above is intended to describe some of the disclosures which might be made, not disclosures which are always or even often made, in any event, the information disclosed without your authorization will be only as much as reasonably necessary to accomplish the intended purpose.

Your Right to Access Personal Information
As an individual, you have certain rights in regards to access to recorded personal information, which is reasonably locatable and retrievable. In order to maintain the security of that information, access will be permitted only after proper identification has been submitted to us.

1. If you have any question about what information we may have on file about you, please write us at the address indicated at the end of this notice. We will need your complete name, address, date of birth and all policy numbers under which you are insured. Tell us what information you would like to receive. Within 30 days of our receipt of your written request, we will:
    a) Inform you of the nature and substance of the recorded personal information in writing, by telephone or by other communication;
    b) Permit you to see and copy, in person (by appointment only,) the recorded personal information which applies to you or provide you with copies of this information by mail;
    c) Any insurance-support organization that furnished the personal information that has been corrected, amended or deleted.
2. If you disagree with a refusal to correct, amend or delete recorded personal information, you may file a:
    a) Concise document setting forth what you think is the correct, relevant or fair information, and a
    b) Concise statement of the reasons why you disagree with the refusal to correct, amend or delete recorded personal information.
3. If you file either of the statements described above, we will:
    a) File the statement with the disputed personal information and provide a means by which anyone reviewing the disputed personal information will be made aware of the statement and have access to it;
    b) In any subsequent disclosure of the recorded personal information that is the subject of disagreement, clearly identify the information in dispute and provide the statements along with the recorded personal information being disclosed;
    c) Furnish the statement to any of the three categories of persons and organizations covered in the preceding point "2."
4. Your rights to correct, amend or delete recorded personal information exist to the extent that the information is collected and maintained in connection with an insurance transaction. These rights do not extend to information about you that relates to and is collected in connection with or in reasonable anticipation of a claim or civil or criminal processing.

Please understand that the above is intended to describe some of the disclosures which might be made, not disclosures which are always or even often made. In any event, the information disclosed without your authorization will only be as much as reasonably necessary to accomplish the intended purpose.

Your Privacy Is Our Concern
Should you have any questions about our procedures or information maintained about you, please contact us at the following address:

Health Care Service Corporation, (A Mutual Legal Reserve Company)
300 East Randolph
Chicago, IL 60601
Attn: SSD – Privacy Act Information

This Important Notice is for coverages provided by Fort Dearborn Life Insurance Company

Fort Dearborn's underwriting process (evaluation and classification of risks) is necessary to assure reasonable cost of insurance and to provide a mechanism by which policyholders and certificate holders pay their fair share of the cost. In considering your application, Fort Dearborn considers information from various sources, including your own statements, the results of your physical examination (if required), and any obtained from doctors or medical facilities where you have been treated.

Information regarding your insurability will be treated as confidential. Fort Dearborn, or its reinsurer(s), may, however, make a brief report thereon to the Medical Information Bureau, Inc. a nonprofit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another Bureau Member Company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the Bureau, upon request, will supply such a company with the information it may have in its file.

Upon receipt of a request from you, the Bureau will arrange a disclosure of any information it may have in your file. If you question the accuracy of the information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with procedures set forth in the Federal Fair Credit Reporting Act. The address of the Bureau's information office is Post Office Box 105, Essex Station, Boston, Massachusetts 02112, telephone number (617) 426-3660.

Fort Dearborn, or its reinsurer(s) may also release information in their file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

The purpose of the Bureau is to protect its member and their policyholders from the extra expense created by those who omit or conceal information relevant to their insurability. Information furnished by the Bureau may serve to alert the company to a need for further investigation but under Bureau rules cannot be used either wholly or partly as the basis for increasing the charge for or denying the issuance of insurance. Information in the Bureau gives no indication regarding the action taken on an application (i.e., whether accepted standard, accepted with increase premium or declined).

BlueCross BlueShield of Illinois

Experience. Wellness. Everywhere.®

Important Notices

I. Initial Notice About Special Enrollment Rights and Pre-existing Condition Exclusion Rules in Your Group Health Plan

A federal law called Health Insurance Portability and Accountability Act (HIPAA) requires that we notify you about two very important provisions in the plan. The first is your right to enroll in the plan under its "special enrollment provision" without being considered a late applicant if you acquire a new dependent or if you decline coverage under this plan for yourself or an eligible dependent while other coverage is in effect and later lose that other coverage for certain qualifying reasons. Second, this notice advises you of the plan's pre-existing condition exclusion rules that may temporarily exclude coverage for certain pre-existing conditions that you or a member of your family may have. Section I of this notice may not apply to certain self-insured, non-federal governmental plans. Contact your employer or plan administrator for more information.

A. SPECIAL ENROLLMENT PROVISIONS

Loss of Other Coverage (Excluding Medicaid or a State Children's Health Insurance Program) If you are declining enrollment for yourself or your eligible dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if you move out of an HMO service area, or the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 31 days after your or your dependents' other coverage ends (or move out of the prior plan's HMO service area, or after the employer stops contributing toward the other coverage).

Loss of Coverage For Medicaid or a State Children's Health Insurance Program
If you decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state children's health insurance program is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after your or your dependents' coverage ends under Medicaid or a state children's health insurance program.

New Dependent by Marriage, Birth, Adoption, or Placement for Adoption
If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

Eligibility for State Premium Assistance for Enrollees of Medicaid or a State Children's Health Insurance Program
If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 60 days after your or your dependents' determination of eligibility for such assistance.

You or your spouse or dependents may also have special enrollment rights in another group health plan at the time a claim is denied as a result of a lifetime limit on all benefits, if you request enrollment within 30 days after the claim has been denied.

To request special enrollment or obtain more information, call Customer Service at the phone number on the back of your Blue Cross and Blue Shield ID card.

B. PRE-EXISTING CONDITION EXCLUSION RULES

Most health plans impose pre-existing condition exclusions. This means that if you have a medical condition before coming to our plan you might have to wait a certain period of time before the plan will provide coverage for that condition. This exclusion applies only to conditions for which medical advice, diagnosis, care or treatment was recommended or received within the six- month period before your enrollment date. Generally, this six-month period ends the day before your coverage becomes effective. However, if you were in a waiting period for coverage, the six-month period ends on the day before the waiting period begins. "Waiting period" generally refers to a delay between the first day of employment and the first day of coverage under the plan. The pre-existing condition exclusion does not apply to pregnancy or to an individual under the age of 19.

This pre-existing condition exclusion may last up to 12 months (18 months if you are a late enrollee) from your first day of coverage, or, if you were in a waiting period, from the first day of your waiting period. However, you can reduce the length of this exclusion period by the number of days you had prior "creditable coverage." Most prior health coverage is creditable coverage and can be used to reduce the pre-existing condition exclusion if you have not experienced a break in coverage of at least 63 days. To reduce the 12-month (or 18-month) exclusion period by your creditable coverage, you should give us a copy of any certificates of creditable coverage you have. If you do not have a certificate, but you do have prior health coverage, you have a right to request one from your prior plan or issuers. We will help you obtain one from your prior plan or issuer, if necessary. There are also other ways that you can show you have creditable coverage. Please contact us if you need help demonstrating creditable coverage.

For more information about the pre-existing condition exclusion and creditable coverage rules affecting your plan, call Customer Service at the phone number on the back of your Blue Cross and Blue Shield ID card.

II. Additional Notices

Other federal laws require we notify you of additional provisions of your plan.

NOTICES OF RIGHT TO DESIGNATE A PRIMARY CARE PROVIDER (FOR NON-GRANDFATHERED HEALTH PLANS ONLY)

For plans that require or allow for the designation of primary care providers by participants or beneficiaries: If the plan generally requires or allows the designation of a primary care provider, you have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, call Customer Service at the phone number on the back of your Blue Cross and Blue Shield ID card.

For plans that require or allow for the designation of a primary care provider for a child: For children, you may designate a pediatrician as the primary care provider.

For plans that provide coverage for obstetric or gynecological care and require the designation by a participant or beneficiary of a primary care provider: You do not need prior authorization from the plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals.

For a list of participating health care professionals who specialize in pediatrics, obstetrics or gynecology, call Customer Service at the phone number on the back of your Blue Cross and Blue Shield ID card.

HIPAA Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.

PLEASE REVIEW IT CAREFULLY.

Our Responsibilities

We are required by applicable federal and state law to maintain the privacy of your protected health information. "Protected health information" (PHI) is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services. We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning your PHI. We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect November 10, 2008, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our notice effective for all PHI that we maintain, including PHI we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this notice and make the new notice available upon request.

For more information about our privacy practices, or for additional copies of this notice, please contact us using the information listed at the end of this notice.

Uses and Disclosures of Protected Health Information

We use and disclose PHI about you for treatment, payment, and health care operations. Following are examples of the types of uses and disclosures that we are permitted to make.

Treatment: We may use or disclose your PHI to a physician or other health care provider providing treatment to you. We may use or disclose your PHI to a health care provider so that we can make prior authorization decisions under your benefit plan.

Payment: We may use and disclose your PHI to make benefit payments for the health care services provided to you. We may disclose your PHI to another health plan, to a health care provider, or other entity subject to the federal Privacy Rules for their payment purposes. Payment activities may include processing claims, determining eligibility or coverage for claims, issuing premium billings, reviewing services for medical necessity, and performing utilization review of claims.

Health Care Operations: We may use and disclose your PHI in connection with our health care operations. Health care operations include the business functions conducted by a health insurer. These activities may include providing customer services, responding to complaints and appeals from members, providing case management and care coordination under the benefit plans, conducting medical review of claims and other quality assessment and improvement activities, establishing premium rates and underwriting rules. In certain instances, we may also provide PHI to the employer who is the plan sponsor of a group health plan.

We may also in our health care operations disclose PHI to business associates[1] with whom we have written agreements containing terms to protect the privacy of your PHI. We may disclose your PHI to another entity that is subject to the federal Privacy Rules and that has a relationship with you for its health care operations relating to quality assessment and improvement activities, reviewing the competence or qualifications of health care professionals, case management and care coordination, or detecting or preventing healthcare fraud and abuse.

Joint Operations: We may use and disclose your PHI connected with a group health plan maintained by your plan sponsor with one or more other group health plans maintained by the same plan sponsor, in order to carry out the payment and health care operations of such an organized health care arrangement.

[1] A "business associate" is a person or entity who performs or assists Blue Cross Blue Shield of Illinois with an activity involving the use or disclosure of medical information that is protected under the Privacy Rules.

On Your Authorization: You may give us written authorization to use your PHI or to disclose it to another person and for the purpose you designate. If you give us an authorization, you may withdraw it in writing at any time. Your withdrawal will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your PHI for any reason except those described in this notice. We will make disclosures of any psychotherapy notes we may have only if you provide us with a specific written authorization or when disclosure is required by law.

Personal Representatives: We will disclose your PHI to your personal representative when the personal representative has been properly designated by you and the existence of your personal representative is documented to us in writing through a written authorization.

Disaster Relief: We may use or disclose your PHI to a public or private entity authorized by law or by its charter to assist in disaster relief efforts.

Health Related Services: We may use your PHI to contact you with information about health related benefits and services or about treatment alternatives that may be of interest to you. We may disclose your PHI to a business associate to assist us in these activities. We may use or disclose your PHI to encourage you to purchase or use a product or service by face-to-face communication or to provide you with promotional gifts.

Public Benefit: We may use or disclose your PHI as authorized by law for the following purposes deemed to be in the public interest or benefit:

- as required by law;
- for public health activities, including disease and vital statistic reporting, child abuse reporting, certain Food and Drug Administration (FDA) oversight purposes with respect to an FDA-regulated product or activity, and to employers regarding work-related illness or injury required under the Occupational Safety and Health Act (OSHA) or other similar laws;
- to report adult abuse, neglect, or domestic violence;
- to health oversight agencies;
- in response to court and administrative orders and other lawful processes;
- to law enforcement officials pursuant to subpoenas and other lawful processes, concerning crime victims, suspicious deaths, crimes on our premises, reporting crimes in emergencies, and for purposes of identifying or locating a suspect or other person;
- to avert a serious threat to health or safety;
- to the military and to federal officials for lawful intelligence, counterintelligence, and national security activities;
- to correctional institutions regarding inmates; and
- as authorized by and to the extent necessary to comply with state worker's compensation laws.

We will make disclosures for the following public interest purposes, only if you provide us with a written authorization or when disclosure is required by law:

- to coroners, medical examiners, and funeral directors;
- to an organ procurement organization; and
- in connection with certain research activities.

Use and Disclosure of Certain Types of Medical Information: For certain types of PHI we may be required to protect your privacy in ways more strict than we have discussed in this notice. We must abide by the following rules for our use or disclosure of certain types of your PHI:

- **HIV Test Information.** We may not disclose the result of any HIV test or that you have been the subject of an HIV test unless required by law or the disclosure is to you or other persons under limited circumstances or you have given us written permission to disclose.
- **Genetic Information.** We may not use or disclose your genetic information unless the use or disclosure is made as required by law or you provide us with written permission to disclose such information.
- **Mental Health Information Records.** We may not disclose your mental health information records except to you and anyone else authorized by law to inspect and copy your mental health information records or you provide us with written permission to disclose.
- **Alcoholism or Drug Abuse Information.** We may not disclose any alcoholism or drug abuse information related to your treatment in an alcohol or drug abuse program unless the disclosure is allowed or required by law or you provide us with written permission to disclose.

Individual Rights

You may contact us using the information at the end of this notice to obtain the forms described here, explanations on how to submit a request, or other additional information.

Access: You have the right, with limited exceptions, to look at or get copies of your PHI contained in a designated record set. A "designated record set" contains records we maintain such as enrollment, claims processing, and case management records. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your PHI and may obtain a request form from us. If we deny your request, we will provide you a written explanation and will tell you if the reasons for the denial can be reviewed and how to ask for such a review or if the denial cannot be reviewed.

Disclosure Accounting: You have the right to receive a list of instances for the 6-year period, but not before April 14, 2003 in which we or our business associates disclosed your PHI for purposes, other than treatment, payment, health care operations, or as authorized by you, and for certain other activities. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests. We will provide you with more information on our fee structure at your request.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your PHI. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency). Any agreement we may make to a request for additional restrictions must be in writing signed by a person authorized to make such an agreement on our behalf. We will not be bound unless our agreement is in writing.

Confidential Communication: You have the right to request that we communicate with you about your PHI by alternative means or to alternative locations. You must make your request in writing. This right only applies if the information could endanger you if it is not communicated by the alternative means or to the alternative location you want. You do not have to explain the basis for your request, but you must state that the information could endanger you if the communication means or location is not changed. We must accommodate your request if it is reasonable, specifies the alternative means or location, and provides satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right, with limited exceptions, to request that we amend your PHI. Your request must be in writing, and it must explain why the information should be amended. We may deny your request if we did not create the information you want amended and the originator remains available or for certain other reasons. If we deny your request, we will provide you a written explanation. You may respond with a statement of disagreement to be attached to the information you wanted amended. If we accept your request to amend the information, we will make reasonable efforts to inform others, including people you name, of the amendment and to include the changes in any future disclosures of that information.

Right to Receive a Copy of the Notice: You may request a copy of our notice at any time by contacting the Privacy Office or by using our website, ***www.bcbsil.com.*** If you receive this notice on our web site or by electronic mail (e-mail), you are also entitled to request a paper copy of the notice.

Questions and Complaints

If you want more information about our privacy practices or have questions or concerns, please contact us using the information listed at the end of this notice.

If you are concerned that we may have violated your privacy rights, you may complain to us using the contact information listed at the end of this notice. You also may submit a written complaint to the U.S. Department of Health and Human Services; see information at its website: *www.hhs.gov.* If you request, we will provide you with the address to file your complaint with the U.S. Department of Health and Human Services.

We support your right to the privacy of your PHI. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact: Director, Privacy Office
Blue Cross Blue Shield of Illinois
P.O. Box 804836
Chicago, IL 60680-4110

You may also contact us using the toll-free number located on the back of your BCBSIL's member identification card.

23175.0211
Rev. 11/10/2008

New Prescription Order Form

BlueCross BlueShield of Illinois

Mail this form to:
PrimeMail®
PO Box 650041
Dallas, TX 75265-0041

For added service:
Visit **www.bcbsil.com**
or call 877.357.7463
TTY 711

Llame la farmacia de PrimeMail en 877.357.7463 o el registro sobre nuestro sitio del web en www.bcbsil.com

CARD HOLDER INFORMATION

Card Holder's ID

Card Holder's Date of Birth (mm/dd/yyyy) / /

Card Holder's Last Name

Card Holder's First Name

MI

Patient's Last Name (if different than card holder's last name)

Patient's First Name

MI

Patient's Gender: ○ Male ○ Female

Patient's Date of Birth (mm/dd/yyyy) / /

Patient's Phone Number – –

Patient's Permanent Address

City

State

Zip Code

Patient's E-mail Address

Contact by: ○ E-mail ○ Phone

DRUG ALLERGIES

○ None ○ Codeine ○ Sulfa
○ Aspirin ○ Erythromycin ○ Penicillin
○ Other _____

HEALTH CONDITIONS

○ Arthritis ○ Diabetes ○ Glaucoma ○ High cholesterol
○ Asthma ○ Depression ○ Heart condition ○ Hypertension
○ Other _____

PATIENT'S NEW PRESCRIPTIONS

Drug Name	Physician/Prescriber's Name & Phone Number	Do not fill at this time
		○
		○
		○

Total Number of Prescriptions: _____

Mail the original physician-signed prescriptions with this completed form. For multiple dependents please use multiple forms. If more than 3 prescriptions are needed, write the requested information from this table on a separate piece of paper and enclose with your order. Additional processing time may be required for prescriptions that require physician clarification. For prescriptions to be filled at a later date, call the customer service number above to activate.

CONTINUED ON BACK

SHIPPING INFORMATION

○ **Regular:** No charge ○ **Second business day:** $15* ○ **Next business day:** $22* ***Additional costs charged to you.**

Shipping time does not include processing time. Shipping prices are subject to change.

We are unable to ship second business day or next business day orders to PO boxes.

Shipping address must be a physical location.

Alternate Shipping Address (if different than permanent address)

City State Zip Code Phone Number

○ This is a change of address ○ This is a one time address ○ Seasonal address from _____ to _____

PAYMENT INFORMATION

Payment is due with each order and may be made by credit card, check or money order. Orders received without payment may delay processing. There is a $20 returned check charge.

Check or money order

Please make check or money order payable to Prime Therapeutics and include your member ID on the memo line. Do not send cash.

○ Check ○ Money Order

Credit card information

To authorize payment by credit card, provide the account number, expiration date and signature. We accept Discover, MasterCard, VISA and American Express. This card will be used for this and all future orders unless we are notified otherwise.

Credit Card Number Expiration Date

○ Use credit card on file, with the last 4 digits of:

Signature _____ Date _____

Pharmacy law may permit pharmacists to substitute a less expensive FDA-approved generically equivalent medication for a brand-name medication unless you or your prescriber indicate otherwise. Some health plans require the patient to pay the difference between generic and brand name cost.

By returning this form to PrimeMail, you consent to the release and use of the patient's health information to the patient's health plans and health care providers/agents for health benefits management. Prime Therapeutics' use or disclosure of individually identifiable health information, whether furnished by you or obtained from other sources such as medical providers, shall be in accordance with federal privacy regulations under HIPAA (Health Insurance Portability and Accountability Act of 1996).

PrimeMail may contact your physician for clarification and safety purposes, which may result in your physician prescribing a different, clinically appropriate product.

Blue Cross and Blue Shield of Illinois (BCBSIL) is a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association.

PrimeMail is a mail-service pharmacy owned and operated by Prime Therapeutics. BCBSIL contracts with Prime Therapeutics to provide pharmacy benefit management and mail-service pharmacy services. In addition, contracting pharmacies are contracted through Prime Therapeutics. The relationship between BCBSIL and contracting pharmacies is that of independent contractors. BCBSIL, as well as several other independent Blue Cross and Blue Shield Plans, has an ownership interest in Prime Therapeutics.

BlueCross BlueShield of Illinois

Experience. Wellness. Everywhere.[SM]

bcbsil.com

90712.0611

BlueCross BlueShield of Illinois

FORT DEARBORN LIFE* Insurance Company®*

APPLICATION AND POLICY CHANGE

DIRECTIONS FOR COMPLETING APPLICATION FORM

Detach these instructions from the application before beginning. Use black or blue ballpoint pen only. Print neatly. Do not abbreviate. **PRESS HARD.**

Complete all fields answering each question as accurately as possible. **If you are unsure or have questions about any of the information requested on this form, please see your GROUP ADMINISTRATOR.**

① **ENROLLEE**: Check the reason you are completing this form.

Timely Enrollment: Your first opportunity to enroll after becoming eligible.

Special Enrollment: You are enrolling within 31 days of a special enrollment event as specified in the Federal HIPAA regulations (e.g., birth, adoption, or placement for adoption, marriage, divorce or involuntary loss of other coverage).

Late Enrollment: You are enrolling at the time other than when first becoming eligible or after a Special Enrollment period ends.

COBRA: You are eligible for continuation of your group health coverage.

Retiree: You are eligible for your group health coverage as a retired employee.

Membership Change: Any change to your current membership such as adding dependents, canceling dependents or changing your benefits. This change may occur outside of Open Enrollment.

Open Enrollment: The period of time offered on a regular basis during which you can elect to enroll in a specific group health insurance plan or make changes to your current membership.

② **EFFECTIVE DATE:** If known, enter effective date, and your Group, Section and Identification Numbers.

③ **COBRA/IL Continuation**: If you are a COBRA/IL Continuation enrollee, enter the start and end date for your COBRA/IL Continuation benefits. The remaining COBRA/IL Continuation information will be completed by Blue Cross and Blue Shield of Illinois.

④ **COVERAGE APPLIED FOR**: Check all coverages that you are enrolling for based on the plans offered by your employer. If you previously had Blue Cross coverage, enter the prior Group, Section and Identification Numbers at the bottom of this section. (If you are enrolling for Family Coverage, be sure to include information on family members in Section ⑦.) **If you are declining coverage, read, complete and sign Sections** ⑤ and ⑪.

⑤ **CHANGES TO EXISTING MEMBERSHIP:** Check all boxes that apply to change coverage, add or cancel dependents, or cancel coverage. If you are changing your PCP or WPHCP, circle the reason(s) why at the bottom of this section.

NOTE: Medical Group/IPA changes are not allowed if a member or dependent is receiving in-hospital care or is in the third trimester of pregnancy.

To **add a dependent,** check the appropriate box. Members may add dependents within 31 days of a qualifying event (e.g., marriage, birth and/or adoption of a child or during open enrollment). Enter the date of the qualifying event. NOTE: List only those dependents to be added in Section ⑦. If coverage is changing from Individual to Family, check the appropriate box in Section ⑥. See your Group Administrator for other requirements to add dependents.

To **cancel a dependent,** check the appropriate box. Enter the date the dependent is to be canceled from coverage. NOTE: List only those dependents to be canceled in Section ⑦. If coverage is changing from Family to Individual, check the appropriate box in Section ⑥.

*Fort Dearborn Life is a separate company that does not provide Blue Cross and Blue Shield of Illinois products or services. Fort Dearborn Life is solely responsible for the life and disability coverage provided.

BlueCross BlueShield of Illinois

FORT DEARBORN LIFE *Insurance Company*®

⑥ **EMPLOYEE INFORMATION**: **Answer every question that applies to you**.
If changing name and/or address, check the appropriate box in Section ⑤ and enter your **NAME** and **ADDRESS** in section ⑥. Be sure that you have completed Section ②.

Enter your Social Security and Identification numbers.

- Include your employee identification number if you know it.
- Your Social Security number is used for internal purposes only.

If you selected **HMO** coverage in Section ④, you must select a Medical Group or IPA and a Primary Care Physician (PCP) for **each person to be covered**. You must also select a Primary Care Physician within the selected Medical Group/IPA **for each person to be covered**. You may choose a different Medical Group/IPA for each person. Female members may choose a Woman's Principal Health Care Provider (WPHCP). A WPHCP may be seen for care without referrals from your PCP, however the PCP and WPHCP must have a referral arrangement with one another. Until we receive your selected medical group information you are not eligible to receive medical services and your claims will be denied. Be sure to enter the Medical Group/IPA number, name, PCP number and name.

If you selected **CPO** or **CPO Value Choice**, you must select a CPO Network.

If you selected **Dental HMO**, include your Dental HMO group number and select a Dental HMO office for **each person to be covered**.

If you are covered by **MEDICARE**, enter your HIC number, which is the Medicare claim number on your Medicare ID card. Enter the start and end dates where they apply for: Medicare A, Medicare B, End Stage Renal Disease (ESRD) Dialysis, and Disability. The ESRD start date is the day ESRD regular course at dialysis begins, (or the date of kidney transplant in the case of total renal failure). The disability start date is the date the beneficiary is entitled to Medicare due to disability.

⑦ **FAMILY COVERAGE INFORMATION**: Answer every question as it applies to your family. If you are changing existing membership, list only those dependents to be added or canceled.

A) **SPOUSE** — Enter complete information for your spouse. If you selected HMO coverage in Section ④, or your spouse is covered by Medicare, complete the HMO and Medicare sections as instructed in Section ⑥.

B) **DEPENDENTS** — Enter complete information for your child(ren). If you selected HMO coverage in Section ④, or your dependent(s) is covered by Medicare, complete the HMO and Medicare sections as instructed in Section ⑥. Space for additional dependents is provided on the second page of this application. If necessary use a separate piece of paper and attach it to this application.

⑧ **OTHER INSURANCE INFORMATION**: If you have other insurance coverage, enter the information requested **completely**. This information will allow for the proper coordination of your health care benefits.

⑨ **FORT DEARBORN LIFE**: If you are enrolling with Fort Dearborn Life, enter the information requested.When listing the Beneficiary provide both the first and last name, and the relationship to you. List all Beneficiaries that apply. If necessary use a separate piece of paper and attach it to this application.

⑩ **SIGNATURE LINE FOR NEW/CHANGING COVERAGE**: Please read, date and sign this Section. **Your signature is required**.

⑪ **SIGNATURE LINE IF DECLINING COVERAGE**: If you are declining coverage, please read this Section and check the appropriate box identifying for whom you are declining coverage and the reason. **Your signature is required**.

BlueCross BlueShield of Illinois

FORT DEARBORN LIFE Insurance Company®

APPLICATION AND POLICY CHANGE

PLEASE PRINT — USE BLACK OR BLUE BALLPOINT PEN ONLY — PRESS HARD.

① ENROLLEE: **New Enrollment:** ☐ Timely ☐ Special ☐ Late | **Open Enrollment:** ☐ New Member ☐ Plan Change ☐ Add Dependents

② EFFECTIVE DATE: ___/___/___ | **Group Number:** | **Section Number:** | **Identification Number:**

③ COBRA / Illinois Continuation Section | **Employee Status:** ☐ Active Employee ☐ COBRA Continuation ☐ IL Continuation ☐ Retiree, retirement date___/___/___

☐ **COBRA:** Start Date ___/___/___ Projected End Date ___/___/___ | ☐ **IL Continuation Privilege:** Start Date ___/___/___ Projected End Date ___/___/___

Previously covered with group as:

☐ 1. Employee (termination of employment, reduction in hours, other.) ☐ 3. Dependent (reach age limit, married, no longer full-time student, other.)

☐ 2. Spouse (divorce from employee, death of employee, other.) ☐ 4. Spouse and Dependents (divorce from employee, death of employee, other.)

④ COVERAGE APPLIED FOR: Check all that apply.**

Medical

☐ Traditional
☐ HMO Illinois
☐ w/HCA (BlueEdge HMO)
☐ BlueAdvantage HMO
☐ w/HCA (BlueEdge HMO)
☐ BlueEdge HSA
☐ Integrated with BCBSIL Vendor
☐ Non-integrated
☐ PPO
☐ BlueEdge HCA
☐ Blue*Choice* Select
☐ BlueEdge Select HSA
☐ Integrated with BCBSIL Vendor
☐ Non-integrated
☐ BlueEdge Select HCA
☐ BlueDecision PPO
☐ PPO Value Choice
☐ CPO
☐ CPO Value Choice
☐ Vision
☐ Hearing
☐ Medicare Supplement

Dental

☐ Individual / Employee ☐ Employee & Spouse ☐ Employee & Child(ren) ☐ Family

Enter Dental Group number if different than Medical Group policy number.

☐ Dental Group #: _____

☐ BlueCare Dental PPO

☐ BlueCare Dental HMO (Select your dental office in section 6 and 7 when applicable)

Fort Dearborn Life Group #: _____

Previous BC (Illinois) or HMO Membership:

Group #: _____ Section #: _____

Identification #: _____

⑤ CHANGES TO EXISTING MEMBERSHIP: Check all that apply.

After checking coverage applied for or making changes to existing membership, complete Group Number, Section Number, Social Security Number and Name.

CHANGES

Date: / /

☐ HMO Medical Group/IPA
☐ PCP and/or WPHCP
☐ Name
☐ Address
☐ Telephone
☐ Reinstate
☐ From PPO to HMO
☐ From HMO to PPO
☐ From HMOI to BA HMO
☐ From BA HMO to HMOI
☐ Medicare Coverage
☐ FDL Beneficiary

ADD DEPENDENTS

Date: / /

☐ Marriage
☐ Newborn
☐ Adoption/Placement
☐ Legal Guardianship
☐ Other: _____

CANCEL DEPENDENTS

Date: / /

☐ Marriage
☐ Divorce
☐ Age Limit
☐ Other: _____

NOTE:
Only list dependents to be added or dropped in the Family Coverage Information Section ⑦.

CANCEL
(Check all that apply)

Date: / /

☐ Terminate Coverage
☐ Waive Coverage**
☐ Leave/Layoff
☐ Out of Service Area Move
☐ Other: _____

***After checking the appropriate physician change, circle reason:**

☐ PCP
☐ WPHCP

A. Availability **B. PCP moved office**
C. Location **D. PCP added to Network**
E. Dissatisfied with PCP **F. PCP office/facility undesirable**
G. Staff **H. Other** _____

****If not electing coverage, please read, complete and sign Section ⑪.**

⑥ EMPLOYEE INFORMATION:

Company Name:

Last Name:	First Name:	Mid. Initial	E-Mail Address:

Street Address:	Apt. No.:	City:	State:	Zip:

Date of Birth: _____/_____/_____ Are You Eligible for Family Coverage: ☐ No ☐ Yes Health Coverage Elected: ☐ Individual/Employee ☐ Employee & Spouse ☐ Employee & Child(ren) ☐ Family

Gender: ☐ Male ☐ Female

Employee Social Security Number: _____ — _____ — _____ Employee Identification Number (if known): _____

Telephone No.: Bus.: (_____) _____ Home: (_____) _____ Date of Hire: _____ / _____ / _____

Dept. No.: _____ Payroll Location: _____ Employee Clock No.: _____

If HMO: Medical Group/IPA #: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ Medical Group/IPA Name: _____

PCP #: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ PCP Name: _____ WPHCP Medical Group/IPA#: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

WPHCP Medical Group Name: ___ ___ ___ ___ ___ ___ ___ ___ WPHCP (Physician) #: ___ ___ ___ ___ ___ ___ ___ ___ ___ WPHCP (Physician) Name: _____

The PCP and WPHCP must have a referral arrangement.

If CPO/CPO Value Choice: Network # CO: _____ **If BlueCare Dental HMO: Office ID#:** _____

Employment Status: ☐ **Actively at Work** ☐ **Retired** **If retired, retirement date:** _____ ☐ **COBRA/IL Continuation**

Are you covered under your employer's health care plan and also covered by Medicare? ☐ **No** ☐ **Yes** **If Yes, the section below must be completed:**

HIC #: _____	MEDICARE B:	ESRD DIALYSIS:	DISABILITY:
MEDICARE A:	Start Date: _____ / _____ / _____	Start Date: _____ / _____ / _____	Start Date: _____ / _____ / _____
Start Date: _____ / _____ / _____	End Date: _____ / _____ / _____	End Date: _____ / _____ / _____	End Date: _____ / _____ / _____

⑦ FAMILY COVERAGE INFORMATION: List All Eligible Dependents.

⑦ Ⓐ SPOUSE: Date of Birth: _____/_____/_____ Last Name (Only If Different): _____

First Name: _____ Social Security Number: _____ — _____ — _____

If HMO: Medical Group/IPA #: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ Medical Group/IPA Name: _____ WPHCP Medical Group/IPA #: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

PCP #: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ PCP Name: _____ WPHCP Medical Group Name: _____

WPHCP (Physician) #: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ WPHCP (Physician) Name: _____ **If BlueCare Dental HMO: Office ID#:** _____

The PCP and WPHCP must have a referral arrangement.

Is this dependent covered under your employer's health care plan and also covered by Medicare? ☐ **No** ☐ **Yes** **If Yes, the section below must be completed:**

HIC #: _____	MEDICARE B:	ESRD DIALYSIS:	DISABILITY:
MEDICARE A:	Start Date: _____ / _____ / _____	Start Date: _____ / _____ / _____	Start Date: _____ / _____ / _____
Start Date: _____ / _____ / _____	End Date: _____ / _____ / _____	End Date: _____ / _____ / _____	End Date: _____ / _____ / _____

BlueCross BlueShield of Illinois

FORT DEARBORN LIFE Insurance Company®

EMPLOYEE AND DEPENDENT INFORMATION: Company Name: Group #:

Employee Last Name: Employee First Name: Mid. Initial

⑦ FAMILY COVERAGE INFORMATION: List All Eligible Dependents.

⑦ Ⓑ ☐ **SON** ☐ **DAUGHTER:** Date of Birth: _____/_____/_____ Last Name (Only If Different): ______________________ First Name: ______________________

Social Security Number: ______________ — ______________ — ______________ **If HMO:** Medical Group/IPA #: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

Medical Group/IPA Name: PCP #: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ PCP Name:______________________WPHCP Medical Group/IPA #: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

WPHCP Medical Group Name: ______________________WPHCP (Physician) #: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ WPHCP (Physician) Name: ______________________

The PCP and WPHCP must have a referral arrangement.
If BlueCare Dental HMO: Office ID#:______________________

Is this dependent covered under your employer's health care plan and also covered by Medicare? ☐ **No** ☐ **Yes If Yes, the section below must be completed:**

HIC #: ______________________ MEDICARE B: ESRD DIALYSIS: DISABILITY:

MEDICARE A: Start Date: ____/____/____ Start Date: ____/____/____ Start Date: ____/____/____

Start Date: ____/____/____ End Date: ____/____/____ End Date: ____/____/____ End Date: ____/____/____

☐ **SON** ☐ **DAUGHTER:** Date of Birth: _____/_____/_____ Last Name (Only If Different): ______________________ First Name: ______________________

Social Security Number: ______________ — ______________ — ______________ **If HMO:** Medical Group/IPA #: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

Medical Group/IPA Name: PCP #: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ PCP Name:______________________WPHCP Medical Group/IPA #: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

WPHCP Medical Group Name: ______________________WPHCP (Physician) #: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ WPHCP (Physician) Name: ______________________

The PCP and WPHCP must have a referral arrangement.
If BlueCare Dental HMO: Office ID#:______________________

Is this dependent covered under your employer's health care plan and also covered by Medicare? ☐ **No** ☐ **Yes If Yes, the section below must be completed:**

HIC #: ______________________ MEDICARE B: ESRD DIALYSIS: DISABILITY:

MEDICARE A: Start Date: ____/____/____ Start Date: ____/____/____ Start Date: ____/____/____

Start Date: ____/____/____ End Date: ____/____/____ End Date: ____/____/____ End Date: ____/____/____

☐ **SON** ☐ **DAUGHTER:** Date of Birth: _____/_____/_____ Last Name (Only If Different): ______________________ First Name: ______________________

Social Security Number: ______________ — ______________ — ______________ **If HMO:** Medical Group/IPA #: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

Medical Group/IPA Name: PCP #: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ PCP Name:______________________WPHCP Medical Group/IPA #: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

WPHCP Medical Group Name: ______________________WPHCP (Physician) #: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ WPHCP (Physician) Name: ______________________

The PCP and WPHCP must have a referral arrangement.
If BlueCare Dental HMO: Office ID#:______________________

Is this dependent covered under your employer's health care plan and also covered by Medicare? ☐ **No** ☐ **Yes If Yes, the section below must be completed:**

HIC #: ______________________ MEDICARE B: ESRD DIALYSIS: DISABILITY:

MEDICARE A: Start Date: ____/____/____ Start Date: ____/____/____ Start Date: ____/____/____

Start Date: ____/____/____ End Date: ____/____/____ End Date: ____/____/____ End Date: ____/____/____

⑧ OTHER INSURANCE INFORMATION:

If you or any of your family members have OTHER GROUP COVERAGE, **Check all that apply.** ☐ Health: Policy #: ______________ ☐ Dental: Policy #: ______________

☐ Prescription Drug Coverage: Policy #: ______________ ☐ Vision: Policy #: ______________ ☐ Hearing: Policy #: ______________

If Yes: Is the other insurance: ☐ Single Coverage ☐ Family Coverage

EMPLOYED BY: ______________________ Insured's Name: ______________________ Date of Birth: _____/_____/_____

Insurance Company Name: ______________________ Address: ______________________

City: ______________________ State: __________ Zip: __________ Telephone Number: ______________________

⑨ FORT DEARBORN LIFE:

Employee Job Title: ______________________ **Class Type:** ______________________

Basic Salary: $ ______________ ☐ **Hourly** ☐ **Weekly** ☐ **Semi-Monthly** ☐ **Monthly** ☐ **Annually**

Check Coverage Applied For: Term Life/AD&D: ☐ No ☐ Yes $ __________ Dependent Life: ☐ No ☐ Yes $ __________ Weekly Income: ☐ No ☐ Yes $ __________

Supplemental Life: ☐ No ☐ Yes $ __________ Long Term Disability: ☐ No ☐ Yes $ __________ ☐ Voluntary AD&D: $ __________ ☐ Single ☐ Family

Permanent Life Insurance: ☐ No ☐ Yes $ __________ **If Yes:** ☐ Automatic Premium Loan or ☐ Replaces An Existing Policy

BENEFICIARY: Note: If more than one Beneficiary, interest will be equal unless otherwise indicated.

Last Name: ______________________ First Name: ______________________ Relationship: ______________________

⑩ **I APPLY FOR COVERAGE AS INDICATED ABOVE**, for which I am or may become eligible under the agreement with Health Care Service Corporation (providing hospital and medical, dental coverage and health maintenance coverage), and/or Fort Dearborn Life Insurance Company (providing the life and disability insurance) (the Company). I have read the above statements and represent they are true and complete to the best of my knowledge. I authorize my employer/group to deduct from my pay and remit any required contribution for the cost of said coverage. This authorization is to remain in effect until the Company is notified by me in writing to the contrary. I understand that the benefits listed in the Certificate(s) will be available subject to the Terms and Conditions thereof effective as listed in the Certificate(s) of Coverage.

Date Signed: ______ / ______ / ______ **Signature of Applicant:** ______________________

⑪ If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 31 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

I DO NOT WISH TO ENROLL at this time and understand that the opportunity to enroll at any future time will be subject to such arrangements as may be made with the Company.

Not enrolling for: ☐ **Myself** ☐ **My spouse** ☐ **My spouse and dependents** ☐ **My dependents** ☐ **Myself, my spouse and my dependents**

Reason: ☐ **Covered under spouse's employer-based health insurance plan (complete "Other Insurance Information" in ⑧)** ☐ **Covered under a Medicare supplement plan**

☐ **Other (please explain)**______________________

Date Signed: ______ / ______ / ______ **Signature of Applicant:** ______________________