Comprehensive Major Medical Plus

Your Health Care
Benefits Policy

BlueCross BlueShield of Illinois

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

DB-41 HCSC

RIGHT TO EXAMINE THIS POLICY

You have the right to examine this Policy for a 30-day period after its issuance. If for any reason you are not satisfied with the health care benefit program described in this Policy, you may return the Policy to Blue Cross and Blue Shield and void your coverage. Any premium paid to Blue Cross and Blue Shield will be refunded to you, provided that you have not had a Claim paid under this Policy before the end of the 30-day period.

GUARANTEED RENEWABILITY

Coverage under this Policy will be terminated for non-payment of premiums. Blue Cross and Blue Shield can refuse to renew this Policy only for the following reasons:

1. If every Policy that bears this Policy form number, DB-41 HCSC, is not renewed. If this should occur:
   a. Blue Cross and Blue Shield will give you at least 90 days prior written notice.
   b. You may convert to any other individual policy Blue Cross and Blue Shield offers to the individual market.
2. In the event of fraud or an intentional misrepresentation of material fact under the terms of this Policy. In this case, Blue Cross and Blue Shield will give you at least 30 days prior written notice.

Blue Cross and Blue Shield will never refuse to renew this Policy because of the condition of your health.

NOTICE OF ANNUAL MEETING

You are hereby notified that you are a Member of Health Care Service Corporation, a Mutual Legal Reserve Company, and you are entitled to vote in person, or by proxy, at all meetings of Blue Cross and Blue Shield. The annual meeting is held at our principal office at 300 East Randolph, Chicago, Illinois each year on the last Tuesday in October at 12:30 p.m.

The term "Member" as used above refers only to the person to whom this Policy is issued. It does not include any other family members covered under Family Coverage unless such family member is acting on your behalf.

A message from

BLUE CROSS AND BLUE SHIELD

Health Care Service Corporation, a Mutual Legal Reserve Company, the Blue Cross and Blue Shield Plan serving the state of Illinois will provide the health care benefit program described in this Policy. In this Policy we refer to our company as "Blue Cross and Blue Shield." Please read your entire Policy very carefully. We hope that most of the questions you have about your coverage will be answered.

THIS POLICY REPLACES ANY PREVIOUS POLICY YOU MAY HAVE BEEN ISSUED BY BLUE CROSS AND BLUE SHIELD.

If you have any questions once you have read this Policy, please contact your local Blue Cross and Blue Shield office. It is important to all of us that you understand the protection this coverage gives you.

Welcome to Blue Cross and Blue Shield! We are happy to have you as a member and pledge you our best service.

Sincerely,

Raymond F. McCaskey
President

Brian Van Vlierbergen
Secretary

NOTICE

Please note that Blue Cross and Blue Shield of Illinois has contracts with many health care Providers that provide for Blue Cross and Blue Shield to receive, and keep for its own account, payments, discounts and/or allowances with respect to the bill for services you receive from those Providers.

Please refer to the provision entitled "Blue Cross and Blue Shield's Separate Financial Arrangements with Providers" in the GENERAL PROVISIONS section of this Policy for a further explanation of these arrangements.

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BENEFIT HIGHLIGHTS

Your health care benefits are highlighted below. To fully understand all the terms, conditions, limitations, and exclusions which apply to your benefits, please read this entire Policy.

LIFETIME BENEFIT MAXIMUM $5,000,000

DEDUCTIBLES

Individual Deductible
and Family Deductible ..... your Deductible amounts are specified on the Schedule Page

Non-PPO/Non-Plan Hospital Inpatient Deductible ..... $300 per admission

OUT-OF-POCKET EXPENSE LIMIT

Individual Out-of-Pocket Limit $1,000

Family Out-of-Pocket Limit $3,000

SPECIAL PROGRAMS

The Medical Services Advisory Program
MSA®'

Registered Mark of
Health Care Service Corporation
a Mutual Legal Reserve Company

Notification to the MSA is required before a non-emergency Inpatient Hospital admission - **subject to a $1,000 Copayment for non-compliance**.

Additional Surgical Opinion

Consultation Payment Level ..... 100% of the Usual and Customary Fee, no Deductible

BENEFIT PAYMENT LEVELS

Hospital Benefits

In a **PPO** Hospital ..... 100% of the Eligible Charge

In a **Non-PPO** Hospital ..... 80% of the Eligible Charge

In a **Non-Plan** Hospital ..... 50% of the Eligible Charge

Physician Benefits and Other Covered Services ..... 80% of the Eligible Charge or Usual & Customary Fee

Emergency Care

Emergency Accident Care and Emergency Medical Care
(Hospital and Physician) ..... 100% of the Eligible Charge or Usual & Customary Fee, no Deductible

Benefit Maximums for

- Well Child Care ..... $500 per calendar year
- Private Duty Nursing Service ..... $1,000 per month
- Chiropractic Service ..... $1,000 per calendar year
- Outpatient Speech Therapy ..... $3,000 per calendar year
- Outpatient Physical Therapy ..... $3,000 per calendar year
- Outpatient Occupational Therapy ..... $3,000 per calendar year
- TMJ ..... $1,000 per lifetime

Outpatient Mental Illness Treatment and
Outpatient Substance Abuse Rehabilitation Treatment

Hospital and Physician Payment Level ..... 50% of the Eligible Charge or Usual & Customary Fee

Calendar Year Maximum $1,000

Inpatient Mental Illness Treatment and
Inpatient Substance Abuse Rehabilitation Treatment

In a **PPO** or **Non-PPO** Hospital ..... 80% of the Eligible Charge for the first 10 days; 50% thereafter

In a **Non-Plan** Hospital ..... 50% of the Eligible Charge

Physician Services ..... 80% of the Usual & Customary Fee

Calendar Year Maximum $10,000

Combined Inpatient/Outpatient Lifetime Maximum $25,000

PRESCRIPTION DRUG PROGRAM BENEFITS

Copayment
- generic ..... $10.00 per prescription
- brand name ..... $25.00 per prescription

Mail Order Prescription Drugs
Copayment
-generic ..... $10.00 per prescription
-brand name ..... $25.00 per prescription

DEFINITIONS SECTION

Throughout this Policy, many words are used which have a specific meaning when applied to your health care coverage. These terms will always begin with a capital letter. When you come across these terms while reading this Policy, please refer to these definitions because they will help you understand some of the limitations or special conditions that may apply to your benefits. If a term within a definition begins with a capital letter, that means that the term is also defined in these definitions.

AMBULANCE TRANSPORTATION . . . . . means local transportation in a specially equipped certified vehicle from your home, scene of accident or medical emergency to a Hospital, between Hospital and Hospital, between Hospital and Skilled Nursing Facility or from a Skilled Nursing Facility or Hospital to your home. If there are no facilities in the local area equipped to provide the care needed, Ambulance Transportation then means the transportation to the closest facility that can provide the necessary service.

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

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

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

ANESTHESIA SERVICES . . . . . means the administration of anesthesia and the performance of related procedures by a Physician or a Certified Registered Nurse Anesthetist which may be legally rendered by them respectively.

AVERAGE DISCOUNT PERCENTAGE ("ADP") . . . . . means a percentage discount determined by Blue Cross and Blue Shield that will be applied to a Provider's Eligible Charge for Covered Services rendered to you by Hospitals and certain other health care facilities for purposes of calculating Coinsurance amounts, deductibles, out-of-pocket maximums and/or any benefit maximums. The ADP will often vary from Claim-to-Claim. The ADP applicable to a particular Claim for Covered Services is the ADP, current on the date the Covered Service is rendered, that is determined by Blue Cross and Blue Shield to be relevant to the particular Claim. The ADP reflects Blue Cross and Blue Shield's reasonable estimate of average payments, discounts and/or other allowances that will result from its contracts with Hospitals and other facilities under circumstances similar to those involved in the particular Claim, reduced by an amount not to exceed 15% of such estimate, to reflect related costs. (See provisions of this Policy regarding "Blue Cross and Blue Shield's Separate Financial Arrangements with Providers.") In determining the ADP applicable to a particular Claim, Blue Cross and Blue Shield will take into account differences among Hospitals and other facilities, Blue Cross and Blue Shield's contracts with Hospitals and other facilities, the nature of the Covered Services involved and other relevant factors.

CERTIFICATE OF CREDITABLE COVERAGE . . . . . .means a certificate disclosing information relating to your Creditable Coverage under a health care benefit program for purposes of reducing any Preexisting Condition exclusion imposed by any group health plan coverage.

CHEMOTHERAPY . . . . . means the treatment of malignant conditions by pharmaceutical and/or biological anti-neoplastic drugs.

CHIROPRACTOR . . . . . means a duly licensed chiropractor.

CHIROPRACTIC SERVICE . . . . . means the performance of chiropractic procedures by a Physician or Chiropractor which may legally be rendered by them respectively.

CLAIM . . . . . means notification in a form acceptable to Blue Cross and Blue Shield that a service has been rendered or furnished to you. This notification must include full details of the service received, including your name, age, sex, identification number, the name and address of the Provider, an itemized statement of the service rendered or furnished, the date of service, the diagnosis, the Claim Charge, and any other information which Blue Cross and Blue Shield may request in connection with services rendered to you.

CLAIM CHARGE . . . . . means the amount which appears on a Claim as the Provider's charge for service rendered to you, without adjustment or reduction and regardless of any separate financial arrangement between Blue Cross and Blue Shield and a particular Provider. (See provisions of this Policy regarding "BLUE CROSS AND BLUE SHIELD'S SEPARATE FINANCIAL ARRANGEMENTS WITH PROVIDERS.")

CLAIM PAYMENT . . . . . means the benefit payment calculated by Blue Cross and Blue Shield, after submission of a Claim, in accordance with the benefits described in this Policy. All Claim Payments will be calculated on the basis of the Eligible Charge for Covered Services rendered to you, regardless of any separate financial arrangement between Blue Cross and Blue Shield and a particular Provider. (See provisions of this Policy regarding "BLUE CROSS AND BLUE SHIELD'S SEPARATE FINANCIAL ARRANGEMENTS WITH PROVIDERS.")

CLINICAL PROFESSIONAL COUNSELOR.....means a duly licensed clinical professional counselor.

CLINICAL SOCIAL WORKER . . . . . means a duly licensed clinical social worker.

COMPLICATIONS OF PREGNANCY . . . . . means all physical effects suffered as a result of pregnancy which would not be considered the effect of normal pregnancy.

COINSURANCE . . . means a percentage of an eligible expense that you are required to pay toward a Covered Service.

COORDINATED HOME CARE PROGRAM . . . . . means an organized skilled patient care program in which care is provided in the home. Such home care may be rendered by the Hospital's duly licensed home health department or by other duly licensed home health agencies. You must be homebound (that is, unable to leave home without assistance and requiring supportive devices or special transportation) and you must require Skilled Nursing Service on an intermittent basis under the direction of your Physician. This program includes, among other things, Skilled Nursing Service by or under the direction of, a registered professional nurse, and the services of physical therapists, hospital laboratories, and necessary medical supplies. The program does not include and is not intended to provide benefits for Private Duty Nursing Service.

A "Plan Coordinated Home Care Program" means a Coordinated Home Care Program which has a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and Blue Shield Plan or Blue Cross Plan to provide service to you at the time service is rendered to you.

A "Non-Plan Coordinated Home Care Program" means a Coordinated Home Care Program which does not have an agreement with a Blue Cross and Blue Shield Plan or Blue Cross Plan but has been certified as a home health agency in accordance with the guidelines established by Medicare.

COPAYMENT . . . . . means a specified dollar amount that you are required to pay towards a Covered Service.

COVERAGE DATE . . . . . means the date on which your coverage under this Policy begins.

COVERED SERVICE . . . . . means a service and supply specified in this Policy for which benefits will be provided.

CREDITABLE COVERAGE . . . . . .means coverage you had under any of the following:

(i) a group health plan;

(ii) health insurance coverage for medical care under any hospital or medical service policy or HMO contract offered by a health insurance issuer;

(iii) Medicare (Part A or B of Title XVIII of the Social Security Act);

(iv) Medicaid (Title XIX of the Social Securitiy Act);

(v) CHAMPUS (Title 10 U. S. C. Chapter 55);

(vi) the Indian Health Service or of a tribal organization;

(vii) a State health benefits risk pool;

(viii) the Federal Employees Health Benefits Program;

(ix) a public health plan maintained by a State, county or other political subdivision of a State;

CRNA ..... means a Certified Registered Nurse Anesthetist who (a) is a graduate of an approved school of nursing and is duly licensed as a registered nurse; (b) is a graduate of an approved program of nurse anesthesia accredited by the Council of Accreditation of Nurse Anesthesia Education Programs/Schools or its predecessors; (c) has been certified by the Council of Certification of Nurse Anesthetists or its predecessors; and (d) is recertified every two years by the Council on Recertification of Nurse Anesthetists.

CUSTODIAL CARE SERVICE ..... means those services which do not require the technical skills or professional training of medical and/or nursing personnel in order to be safely and effectively performed. Examples of Custodial Care Service are: assistance with activities of daily living, administration of oral medications, assistance in walking, turning and positioning in bed, and acting as a companion or sitter. Custodial Care Service also means providing Inpatient service and supplies to you if you are not receiving Skilled Nursing Service on a continuous basis and/or you are not under a specific therapeutic program which has a reasonable expectancy of improving your condition within a reasonable period of time and which can only be safely and effectively administered to you as an Inpatient in the health care facility involved.

DEDUCTIBLE ..... means the amount of expense that you must incur in Covered Services before benefits are provided.

DENTIST ..... means a duly licensed dentist.

DIAGNOSTIC SERVICE ..... means tests rendered for the diagnosis of your symptoms and which are directed toward evaluation or progress of a condition, disease or injury. Such tests include, but are not limited to, x-ray, pathology services, clinical laboratory tests, pulmonary function studies, electrocardiograms, electroencephalograms, radioisotope tests, and electromyograms.

DIALYSIS FACILITY ..... means a facility (other than a Hospital) whose primary function is the treatment and/or provision of maintenance and/or training dialysis on an ambulatory basis for renal dialysis patients and which is duly licensed by the appropriate governmental authority to provide such services.

A "Plan Dialysis Facility" means a Dialysis Facility which has a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and Blue Shield Plan or Blue Cross Plan to provide services to you at the time services are rendered to you.

A "Non-Plan Dialysis Facility" means a Dialysis Facility which does not have an agreement with a Blue Cross and Blue Shield Plan or Blue Cross Plan but has been certified in accordance with the guidelines established by Medicare.

ELIGIBLE CHARGE ..... means, in the case of a Provider which has a written agreement with Blue Cross and Blue Shield, such Provider's Claim Charge for Covered Services or, in the case of a Provider which does not have a written agreement with Blue Cross and Blue Shield, either of the following charges for Covered Services as determined at the discretion of Blue Cross and Blue Shield:

(a) the charge which the particular Hospital or facility usually charges its patients for Covered Services; or

(b) the charge which is within the range of charges other similar Hospitals or facilities in similar geographic areas charge their patients for the same or similar services, as reasonably determined by Blue Cross and Blue Shield.

EMERGENCY ACCIDENT CARE . . . . . means the initial Outpatient treatment of accidental injuries including related Diagnostic Service.

EMERGENCY MEDICAL CARE . . . . . means services provided for the initial Outpatient treatment, including related Diagnostic Service, of a medical condition displaying itself by symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect that the absence of immediate medical attention could result in: (i) placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (ii) serious impairment to bodily functions; or (iii) serious dysfunction of any bodily organ or part.

Examples of symptoms that may indicate the presence of an emergency medical condition include, but are not limited to difficulty breathing, severe chest pains, convulsions or persistent severe abdominal pains.

EMERGENCY MENTAL ILLNESS ADMISSION . . . . . means an admission for the treatment of Mental Illness as a result of the sudden and unexpected onset of a mental condition that the absence of immediate medical treatment would likely result in serious and permanent medical consequences to oneself or others.

Examples of Mental Illness are: major depression with significant suicidal intent, psychosis with associated homicidal intent or a manic episode resulting in inability to care for oneself.

EVIDENCE OF INSURABILITY . . . . means proof satisfactory to Blue Cross and Blue Shield that your health is acceptable for insurance. Blue Cross and Blue Shield may require, among other things, proof of age or a Physician's report.

FAMILY COVERAGE . . . . . means coverage for you and your eligible dependents under this Policy.

HOSPICE CARE PROGRAM PROVIDER. . . . . means an organization duly licensed to provide Hospice Care Program Service.

HOSPICE CARE PROGRAM SERVICE. . . . . .means a centrally administered program of palliative and supportive services, providing physical, psychological, social and spiritual care for dying persons and their families. The goal of hospice care is to allow the dying process to proceed with a minimum of patient discomfort while maintaining dignity and a quality of life. Hospice Care Program Service is available in the home, Skilled Nursing Facility or hospice care unit.

HOSPITAL . . . . . means a duly licensed institution for the care of the sick which provides service under the care of a Physician including the regular provision of bedside nursing by registered nurses. It does not mean health resorts, rest homes, nursing homes, skilled nursing facilities, convalescent homes, custodial homes of the aged or similar institutions.

A "Plan Hospital" means a Hospital which has a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and Blue Shield Plan or Blue Cross Plan to provide services to you at the time services are rendered to you.

A "Non-Plan Hospital" means a Hospital that does not meet the definition of a Plan Hospital.

A "PPO Hospital" means a Plan Hospital that has an agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and Blue Shield Plan or Blue Cross Plan to provide Hospital services to participants in the Participating Provider Option program.

A "Non-PPO Hospital" means a Hospital that does not meet the definition of a PPO Hospital.

INDIVIDUAL COVERAGE . . . . . means coverage under this Policy for yourself but not your spouse and/or dependents.

INPATIENT . . . . . means that you are a registered bed patient and are treated as such in a health care facility.

INVESTIGATIONAL OR INVESTIGATIONAL SERVICES AND SUPPLIES . . . . means procedures, drugs, devices, services and/or supplies which (1) are provided or performed in special settings for research purposes or under a controlled environment and which are being studied for safety, efficiency and effectiveness and/or (2) are awaiting endorsement by the appropriate National Medical Speciality College or federal government agency for general use by the medical community at the time they are rendered to you, and (3) specifically with regard to drugs, combinations of drugs and/or devices, are not finally approved by the Federal Drug Administration at the time used or administered to you.

MAINTENANCE OCCUPATIONAL THERAPY, MAINTENANCE PHYSICAL THERAPY, and/or MAINTENANCE SPEECH THERAPY . . . . . means therapy administered to you to maintain a level of function at which no demonstrable and measurable improvement of a condition will occur.

MATERNITY SERVICE . . . . . means the services rendered for normal pregnancy. A normal pregnancy means an intrauterine pregnancy which, through vaginal delivery, results in an infant who weighs five pounds or more.

MEDICAL CARE . . . . . means the ordinary and usual professional services rendered by a Physician or other specified Provider during a professional visit for treatment of an illness or injury.

MEDICALLY NECESSARY . . . . . SEE EXCLUSIONS SECTION OF THIS POLICY.

MEDICARE . . . . . means the program established by Title XVIII of the Social Security Act (42 U.S.A. 1395 et seq.).

MEDICARE APPROVED or MEDICARE PARTICIPATING . . . . . means a Provider which has been certified or approved by the Department of Health and Human Services for participation in the Medicare program.

MENTAL ILLNESS . . . . . means those illnesses classified as disorders in the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association which is current as of the date services are rendered to you.

NAPRAPATH . . . . . means a duly licensed naprapath.

NAPRAPATHIC SERVICES . . . . . means the performance of naprapathic practice by a Naprapath which may legally be rendered by them.

NON-PPO HOSPITAL . . . . . see definition of HOSPITAL

NON-PLAN PROVIDER . . . . . see definition of PROVIDER

OCCUPATIONAL THERAPY . . . . . means constructive therapeutic activity designed and adapted to promote the restoration of useful physical function. Occupational Therapy does not include educational training or services designed and adapted to develop a physical function.

OPTOMETRIST . . . . . means a duly licensed optometrist.

OUTPATIENT . . . . . means that you are receiving treatment while not an Inpatient.

PARTIAL HOSPITALIZATION TREATMENT PROGRAM . . . . . means a Blue Cross and Blue Shield approved planned program of a Hospital or Substance Abuse Treatment Facility for the treatment of Mental Illness or Substance Abuse Rehabilitation Treatment in which patients spend days or nights.

PARTICIPATING PROVIDER OPTION (PPO) . . . . . means a program of health care benefits designed to provide you with economic incentives for using designated Providers of health care services.

PPO HOSPITAL . . . . . see definition of HOSPITAL

PHARMACY . . . . means any licensed establishment in which the profession of pharmacy is practiced.

PHYSICAL THERAPY . . . . . means the treatment of a disease, injury or condition by physical means by a Physician or registered professional physical therapist under the supervision of a Physician and which is designed and adapted to promote the restoration of a useful physical function. Physical Therapy does not include educational training or services designed and adapted to develop a physical function.

PHYSICIAN . . . . means a physician duly licensed to practice medicine in all of its branches.

PODIATRIST . . . . means a duly licensed podiatrist.

POLICY . . . . . means this booklet, including your application for coverage under the Blue Cross and Blue Shield benefit program described in this booklet.

PREEXISTING CONDITION . . . . . means any disease, illness, sickness, malady or condition which was diagnosed or treated by a Provider within 12 months prior to your Coverage Date, or which produced symptoms within 12 months prior to your Coverage Date which would have caused an ordinarily prudent person to seek medical diagnosis or treatment.

PRIVATE DUTY NURSING SERVICE . . . . . means Skilled Nursing Service provided on a one-to-one basis by an actively practicing registered nurse or licensed practical nurse who is not providing this service as an employee or agent of a Hospital or other health care facility. Private Duty Nursing Service does not include Custodial Care Service.

PROVIDER . . . . . means any health care facility (for example, a Hospital or Skilled Nursing Facility) or person (for example, a Physician or Dentist) or entity duly licensed to render Covered Services to you.

A "Plan Provider" means a Provider which has a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and Blue Shield Plan or Blue Cross Plan to provide services to you at the time services are rendered to you.

A "Non-Plan Provider" means a Provider that does not meet the definition of Plan Provider unless otherwise specified in the definition of a particular Provider.

PSYCHOLOGIST . . . . . means a Registered Clinical Psychologist.

Registered Clinical Psychologist means a Clinical Psychologist who is registered with the Illinois Department of Registration and Education pursuant to the Illinois "Psychologists Registration Act" or, in a state where statutory licensure exists, the Clinical Psychologist must hold a valid credential for such practice or, if practicing in a state where statutory licensure does not exist, such person must meet the qualifications specified in the definition of a Clinical Psychologist.

Clinical Psychologist means a psychologist who specializes in the evaluation and treatment of Mental Illness and who meets the following qualifications:

has a doctoral degree from a regionally accredited University, College or Professional School; and has two years of supervised experience in health services of which at least one year is post-doctoral and one year in an organized health services program; or

is a Registered Clinical Psychologist with a graduate degree from a regionally accredited University or College; and has not less than six years as a psychologist with at least two years of supervised experience in health services.

RENAL DIALYSIS TREATMENT . . . . . means one unit of service including the equipment, supplies and administrative service which are customarily considered as necessary to perform the dialysis process.

SKILLED NURSING FACILITY . . . . . means an institution or a distinct part of an institution which is primarily engaged in providing comprehensive post-acute Hospital and rehabilitative Inpatient care and is duly licensed by the appropriate governmental authority to provide such services. It does not mean institutions which provide only minimal care, Custodial Care Services, ambulatory or part-time care services or institutions which primarily provide for the care and treatment of Mental Illness, pulmonary tuberculosis or Substance Abuse.

A "Plan Skilled Nursing Facility" means a Skilled Nursing Facility which has a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and Blue Shield Plan or Blue Cross Plan to provide services to you at the time services are rendered to you.

A "Non-Plan Skilled Nursing Facility" means a Skilled Nursing Facility which does not have an agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and Blue Shield Plan or Blue Cross Plan but has been certified in accordance with guidelines established by Medicare.

An "Uncertified Skilled Nursing Facility" means a Skilled Nursing Facility which does not have an agreement with Blue Cross and Blue Shield and has not been certified in accordance with guidelines established by Medicare.

SKILLED NURSING SERVICE . . . . . means those services provided by a registered nurse (R.N.) or licensed practical nurse (L.P.N.) which require the technical skills and professional training of an R.N. or L.P.N. and which cannot reasonably be taught to a person who does not have specialized skills and professional training. Skilled Nursing Service does not include Custodial Care Service.

SPEECH THERAPY . . . . . means the treatment for the correction of a speech impairment resulting from disease, trauma, congenital anomalies or previous therapeutic processes and which is designed and adapted to promote the restoration of a useful physical function. Speech Therapy does not include educational training or services designed and adapted to develop a physical function.

SUBSTANCE ABUSE . . . . . means the uncontrollable or excessive abuse of addictive substances consisting of alcohol, morphine, cocaine, heroin, opium, cannabis, and other barbiturates, amphetamines, tranquilizers and/or hallucinogens, and the resultant physiological and/or psychological dependency which develops with continued use of such addictive substances requiring Medical Care as determined by a Physician or Psychologist.

SUBSTANCE ABUSE REHABILITATION TREATMENT . . . . . means an organized, intensive, structured, rehabilitative treatment program of either a Hospital or Substance Abuse Treatment Facility. It does not include programs consisting primarily of counseling by individuals other than a Physician, Psychologist or Clinical Social Worker, court ordered evaluations, programs which are primarily for diagnostic evaluations, mental retardation or learning disabilities, care in lieu of detention or correctional placement or family retreats.

SUBSTANCE ABUSE TREATMENT FACILITY . . . . . means a facility (other than a Hospital) whose primary function is the treatment of Substance Abuse and is licensed by the appropriate state and local authority to provide such service. It does not include half-way houses, boarding houses, or other facilities that provide primarily a supportive environment, even if counseling is provided in such facilities.

A "Plan Substance Abuse Treatment Facility" means a Substance Abuse Treatment Facility which has a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and Blue Shield Plan or Blue Cross Plan to provide services to you at the time services are rendered to you.

A "Non-Plan Substance Abuse Treatment Facility" means a Substance Abuse Treatment Facility that does not meet the definition of a Plan Substance Abuse Treatment Facility.

SURGERY . . . . means the performance of any medically recognized, non-Investigational surgical procedure including specialized instrumentation and the correction of fractures or complete dislocations and any other procedures as reasonably approved by Blue Cross and Blue Shield.

TEMPOROMANDIBULAR JOINT DYSFUNCTION AND RELATED DISORDERS (TMJ) . . . . . means jaw joint conditions including temporomandibular joint disorders and craniomandibular disorders, and all other conditions of the joint linking the jaw bone and skull and the complex of muscles, nerves and other tissues relating to that joint.

USUAL AND CUSTOMARY FEE . . . . . means the fee as reasonably determined by Blue Cross and Blue Shield, which is based on the fee which the Physician, Dentist, Podiatrist, Psychologist, Clinical Social Worker, Chiropractor or Optometrist who renders the particular service usually charges his patients for the same service and the fee which is within the range of usual fees other Physicians, Dentists, Podiatrists, Psychologists, Clinical Social Workers, Chiropractors or Optometrists of similar training and experience in a similar geographic area charge their patients for the same service, under similar or comparable circumstances. However, if Blue Cross and Blue Shield reasonably determines that the Usual and Customary Fee for a particular service is unreasonable because of extenuating or unusual circumstances, the Usual and Customary Fee for such service shall mean the reasonable fee as reasonably determined by Blue Cross and Blue Shield.

COVERAGE AND PREMIUM INFORMATION

YOUR APPLICATION FOR COVERAGE

Any omission or misstatement of a material fact on your application will result in the cancellation of your coverage (and/or your dependent's coverage) retroactive to the Coverage Date. In the event of such cancellation, Blue Cross and Blue Shield will refund any premiums paid during the period for which cancellation is effected. However, Blue Cross and Blue Shield will deduct from the premium refund any amounts made in Claim Payments during this period and you will be liable for any Claim Payment amounts greater than the total amount of premiums paid during the period for which cancellation is effected.

YOUR BLUE CROSS AND BLUE SHIELD ID CARD

You will receive a Blue Cross and Blue Shield identification card. This card will tell you your Blue Cross and Blue Shield identification number and will be very important to you in obtaining your benefits.

YOUR SCHEDULE PAGE

A Schedule Page has been inserted into and is part of this Policy. Specific information about your coverage under this Policy is contained on the Schedule Page, such as whether you have Individual Coverage or Family Coverage, the premium payment mode that you have selected and the amount of your Deductible.

INDIVIDUAL COVERAGE

If you have Individual Coverage, only your own health care expenses are covered, not the health care expenses of other members of your family.

FAMILY COVERAGE

If you have Family Coverage, your health care expenses and those of your enrolled spouse and your (or your spouse's) enrolled unmarried children who are under age 19 will be covered. Enrolled unmarried children who are full-time students will be covered up to age 25. Coverage for unmarried children will end on the 19th or 25th birthday. Coverage for children who get married ends on the date of their marriage.

Under Family Coverage, any newborn children will be covered from the moment of birth, as long as you notify Blue Cross and Blue Shield within 31 days of the birth. If you do not notify us within 31 days, you will be required to provide Evidence of Insurability to enroll your child.

Any children who are dependent upon you or other care providers for support and maintenance because of a handicapped condition will be covered regardless of age if they were covered prior to reaching the limiting age stated above.

For purposes of this section, dependent on other care providers means requiring a Community Integrated Living arrangement, group home, supervised apartment, or other residential services licensed or certified by the Department of Human Services (as successor to the Department of Mental Health and Developmental Disabilities), the Department of Public Health, or the Department of Public Aid.

Blue Cross and Blue Shield may inquire 60 days prior to the dependent reaching the limiting age, or at any reasonable time thereafter, whether the dependent is in fact a disabled and dependent person. You must provide proof within 60 days of the inquiry that the dependent is a disabled and dependent person. If you do not provide proof within the 60 days, coverage will automatically terminate on the birthday on which the dependent reaches the limiting age.

Any children who are in your custody under an interim court order prior to finalization of adoption will be covered.

This coverage does not include benefits for foster children or grandchildren.

CHANGING FROM INDIVIDUAL TO FAMILY COVERAGE OR ADDING DEPENDENTS TO FAMILY COVERAGE

You can change from Individual to Family Coverage or add additional dependents to your Family Coverage as follows:

Evidence of Insurability is required to add your spouse, whether your spouse is being added to your existing Family Coverage or you are changing to Family Coverage. If you make application to add your spouse within 31 days of the marriage, your spouse's coverage or your Family Coverage will be effective as of the date of marriage, provided that the application is approved by Blue Cross and Blue Shield. If application is not made within 31 days of the marriage, coverage, if approved, will be effective on a date determined by Blue Cross and Blue Shield.

Evidence of Insurability is not required to add a dependent child if application is made to add the child within 31 days of the child's birth or adoption or date of interim court order pending adoption. Such child's coverage or your Family Coverage will be effective as of the date of birth, adoption or court order. If application is not made within 31 days of the birth, adoption or court order, Evidence of Insurability for the child is required and coverage will be effective upon approval of Evidence of Insurability on a date determined by Blue Cross and Blue Shield.

CHANGING FROM FAMILY TO INDIVIDUAL COVERAGE

You can change from Family Coverage to Individual Coverage at any time by contacting Blue Cross and Blue Shield for an application. The change will be effective on a date determined by Blue Cross and Blue Shield.

OTHER COVERAGE CHANGES

Divorce

If you become divorced while you have Family Coverage under this Policy, your covered spouse is entitled to have issued to him or her, without Evidence of Insurability, and within 60 days following the entry of the divorce decree, a new Policy of the same type. Your dependent children may either continue coverage under your Policy, become covered under your spouse's new Policy or change to separate Individual Coverage Policies (but only if you and your spouse have both elected Individual Coverage). Any Preexisting Conditions Waiting Period applicable to the new Policy(ies) shall be considered as being met to the extent that such waiting period was satisfied under this Policy.

In the Event of your Death

In the event of your death, your covered spouse is entitled to have issued to him or her, without Evidence of Insurability and upon application within 60 days following the date of your death, a new Policy of the same type. Your spouse may elect to continue Family Coverage or change to Individual Coverage. In the event your spouse elects Individual Coverage and there are covered dependent children, those dependent children are entitled to have issued to each of them, separate Individual Coverage Policies, without Evidence of Insurability and provided that application is made within 60 days following your death or following your spouse's election of Individual Coverage. Any Preexisting Conditions Waiting Period applicable to the new Policy(ies) shall be considered as being met to the extent that such waiting period was satisfied under this Policy.

Covered Dependent Children

If a covered dependent child marries, obtains full-time employment or reaches the limiting age, he or she may convert to a separate "conversion policy" on an Individual Coverage basis only. He or she may not convert to a conversion policy providing Family Coverage. Evidence of Insurability will not be required and any Preexisting Conditions Waiting Period applicable to the conversion policy shall be considered as being met to the extent that such waiting period was satisfied under this Policy. If the former dependent child elects to apply for an Individual Coverage policy other than the conversion policy, Evidence of Insurability will be required.

PAYMENT OF PREMIUMS

1. Your first premium is due on your Coverage Date. Later premiums are due and payable on the due date, which is dependent upon the premium mode selected. The premium mode you selected is shown on the Schedule Page of this Policy.
2. The initial premium for Individual Coverage is based on your age at the time your coverage commences and the initial premium for Family Coverage is based on your age, your spouse's age and any eligible dependent children at the time coverage is applied for.

3. Blue Cross and Blue Shield may establish a new premium for any of the benefits of this Policy on any of the following dates or occurrences:

   a. any premium due date, provided Blue Cross and Blue Shield notifies you of the new premium amount at least 30 days in advance of such premium due date;

   b. whenever the benefits of this Policy are increased, which may occur whenever required by law or whenever Blue Cross and Blue Shield gives notice of an increase in benefits;

   c. whenever you or your spouse attain an age which results in a change in the premium amount due for that age category of coverage;

   d. whenever the number of persons covered under this Policy is changed;

   e. whenever you move your residence from one geographical rating area to another.

4. If the ages upon which the premium is based have been misstated, an amount which will provide Blue Cross and Blue Shield with the correct premium from your Coverage Date shall be due and payable upon billing or receipt from Blue Cross and Blue Shield.

5. If you fail to pay premiums to Blue Cross and Blue Shield within 31 days of the premium due date, this Policy will automatically terminate. Benefits will not be provided for expenses incurred during this 31-day grace period or thereafter unless the premiums are paid within this period.

REINSTATEMENT

If any premium is not paid within the time granted you for payment, a subsequent acceptance of premium by Blue Cross and Blue Shield or by any agent duly authorized by Blue Cross and Blue Shield to accept such premium, without requiring an application for reinstatement in connection with the premium payment, shall reinstate the Policy. However, if Blue Cross and Blue Shield or such agent requires an application for reinstatement and issues a conditional receipt for the premium given, the Policy will be reinstated upon approval of such application by Blue Cross and Blue Shield or, lacking such approval, upon the 45th day following the date of such conditional receipt unless Blue Cross and Blue Shield has previously notified you in writing of its disapproval of such application.

The reinstated Policy shall cover only loss resulting from such accidental injury as may be sustained after the date of reinstatement and loss due to such illness as may begin more than 10 days after such date. In all other respects you will have the same rights as you had under the Policy immediately before the due date of the defaulted premium, subject to any provisions endorsed and attached hereto in connection with reinstatement. Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than 60 days prior to the date of reinstatement.

CERTIFICATE OF CREDITABLE COVERAGE

Upon termination of your coverage under this Policy, you will be issued a Certificate of Creditable of Coverage. You may request a Certificate of Creditable Coverage within 24 months of termination of your or your dependent's (if applicable) coverage under this Policy.

EXTENSION OF BENEFITS IN CASE OF TERMINATION

If you are an Inpatient at the time your coverage under this Policy is terminated, benefits will be provided for, and limited to, the Covered Services which are provided by and regularly charged for by a Hospital, Skilled Nursing Facility, Substance Abuse Treatment Facility, Partial Hospitalization Treatment Program or Coordinated Home Care Program. Benefits will be provided until you are discharged or until you reach any maximum benefit amount which may apply, whichever occurs first. No other benefits will be provided after your coverage under this Policy is terminated.

BENEFIT INFORMATION

Before reading the description of your benefits, you should understand the terms described below.

PREEXISTING CONDITIONS WAITING PERIOD

Your benefits are subject to a Preexisting Conditions waiting period of 365 days. The Preexisting Conditions waiting period will begin on your Coverage Date for you and your eligible dependents (if you have Family Coverage) and will continue for 365 days. This Preexisting Conditions waiting period will also apply to each dependent (other than a newborn child, if application for coverage is made within 31 days of birth) for whom coverage is applied for after your Coverage Date. The Preexisting Conditions waiting period for such a dependent will begin on the dependent's Coverage Date. Until the Preexisting Conditions waiting period has ended, no benefits will be provided for a Preexisting Condition.

YOUR DEDUCTIBLES

Each calendar year you must satisfy a **Deductible** before receiving benefits under this Policy. The amount of your Deductible is indicated on the Schedule Page of this Policy. After you have claims for Covered Services in a calendar year which exceed this Deductible amount, your benefits will begin. In addition to this calendar year Deductible, you must satisfy a separate **$300 Inpatient Hospital Deductible** each time you are admitted to a Non-PPO Hospital or Non-Plan Hospital.

If you have any expenses for Covered Services during the last three months of a calendar year which were or could have been applied to that year's Deductible, those expenses may be applied toward the Deductible of the next year.

If you have Family Coverage and your family has satisfied the family Deductible amount shown on the Schedule Page, it will not be necessary for anyone else in your family to meet a Deductible in that calendar year. That is, for the remainder of that calendar year, no other family members will be required to meet the Deductible before receiving benefits. No more than the amount of the individual Deductible can be applied to the family Deductible by any one family member.

In any case, should two or more members of your family ever receive Covered Services as a result of injuries received in the same accident, only one Deductible will be applied against those Covered Services.

Not all of the Covered Services described in this Policy are subject to your Deductible. The following Covered Services are not subject to the Deductible:

EMERGENCY ACCIDENT CARE

EMERGENCY MEDICAL CARE

ADDITIONAL SURGICAL OPINION CONSULTATIONS

MEDICAL SERVICES ADVISORY PROGRAM (MSA)

Blue Cross and Blue Shield has established the Medical Services Advisory Program (MSA) to perform a review of Inpatient Hospital Covered Services **prior to** such services being rendered.

The MSA Program is staffed primarily by registered nurses and other personnel with clinical backgrounds. The Physicians in our Medical Department are an essential part of the MSA Program.

Failure to contact the MSA or to comply with the determinations of the MSA will result in a reduction in benefits. The MSA's toll-free telephone number is on your Blue Cross and Blue Shield identification card. Please read the provisions below very carefully.

PREADMISSION REVIEW

- **Inpatient Hospital Preadmission Review**

  Preadmission Review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations and exclusions of this Policy and the Preexisting Conditions Waiting Period, if any.

  Whenever a nonemergency Inpatient Hospital admission is recommended by your Physician, you must, in order to receive maximum benefits under this Policy, call the MSA. This call should be made at least one business day prior to the scheduling of the Hospital admission and the performance of any preadmission tests.

  If the proposed Hospital admission does not meet Medically Necessary criteria, it will be referred to a Blue Cross and Blue Shield Physician. If the Blue Cross and Blue Shield Physician concurs that the proposed admission does not meet the criteria for Medically Necessary care, some benefit days or the entire hospitalization will be denied. You and your Physician will be verbally advised of this determination, with a follow-up notification letter sent to you, your Physician and the Hospital. The MSA will issue these notification letters promptly. However, in some instances these letters will not be received prior to the scheduled date of admission.

- **Emergency Admission Review**

  Emergency Admission Review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations and exclusions of this Policy and the Preexisting Conditions Waiting Period, if any.

  In the event of an emergency admission, you or someone who calls on your behalf, must, in order to receive maximum benefits under this Policy, notify the MSA no later than two business days or as soon as reasonably possible after the admission has occurred. If the call is made any later than the specified time period, you will not receive maximum benefits.

CASE MANAGEMENT

After your case has been evaluated, you may be assigned a case manager. In some cases, if your condition would require care in a Hospital or other health care facility, the case manager may recommend an alternative treatment plan.

Alternative benefits will be provided only so long as Blue Cross and Blue Shield determines that the alternative services are Medically Necessary and cost effective. The case manager will continue to monitor your case for the duration of your condition. The total maximum payment for alternative services shall not exceed the total benefits for which you would otherwise be entitled under this Policy.

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

LENGTH OF STAY/SERVICE REVIEW

Length of stay/service review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of this Policy as well as the Preexisting Condition waiting period, if any.

Upon completion of the preadmission or emergency admission review, the MSA will send you a letter confirming that you or your representative called the MSA. A letter assigning a length of service or length of stay will be sent to your Physician and/or the Hospital.

An extension of the length of stay/service will be based solely on whether continued Inpatient care or other health care service is Medically Necessary as determined by the MSA. In the event that the extension is determined not to be Medically Necessary, the length of stay/service will not be extended, and the case will be referred to a Blue Cross and Blue Shield Physician for review.

MEDICALLY NECESSARY DETERMINATION

The decision that Inpatient care or other health care services or supplies are not Medically Necessary will be determined by the MSA. Should the Blue Cross and Blue Shield Physician find that the Inpatient care or other health care services or supplies are not Medically Necessary, written notification of the decision will be provided to you, your Physician, and/or the Hospital or other Provider, and will specify the dates that are not in benefit. For further details regarding Medically Necessary care and other exclusions from coverage under this Policy, refer to the section entitled, "EXCLUSIONS - WHAT IS NOT COVERED."

The MSA does not determine the course of treatment or whether you receive particular health care services. The decision regarding the course of treatment and receipt of particular health care services is a matter entirely between you and your Physician. The MSA's determination of Medically Necessary care is limited to merely whether a proposed admission, continued hospitalization or other health care service is Medically Necessary under this Policy.

In the event that Blue Cross and Blue Shield determines that all or any portion of an Inpatient hospitalization or other health care service is not Medically Necessary, Blue Cross and Blue Shield will not be responsible for any related Hospital or other health care service charge incurred.

Remember that your Blue Cross and Blue Shield Policy does not cover the cost of hospitalization or any health care services and supplies that are not Medically Necessary. The fact that your Physician or another health care Provider may prescribe, order, recommend or approve an Inpatient admission or continued Inpatient hospitalization beyond the length of stay authorized by the Blue Cross and Blue Shield Physician does not of itself make such an Inpatient Hospital stay Medically Necessary. Even if your Physician prescribes, orders, recommends, approves or views an Inpatient admission or continued Inpatient hospitalization beyond the length of stay assigned by the MSA as Medically Necessary, Blue Cross and Blue Shield will not pay for an Inpatient admission or continued hospitalization which exceeds the assigned length of stay if the MSA and the Blue Cross and Blue Shield Physician decides an extension of the assigned length of stay is not Medically Necessary.

MSA PROCEDURE

When you contact the MSA, you should be prepared to provide the following information:

1. the name of the attending and/or admitting Physician;
2. the name of the Hospital where the admission has been scheduled;
3. the scheduled admission and/or service date; and
4. a preliminary diagnosis or reason for the admission.

When you contact the MSA, the MSA:

1. will review the medical information provided and may follow up with the Provider;
2. may determine that the services to be rendered are not Medically Necessary.

APPEAL PROCEDURE

If you or your Physician disagree with the recommendations of the MSA prior to or while receiving services, that decision may be appealed by contacting the MSA or Blue Cross and Blue Shield's Medical Department.

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

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

You must exercise the right to this appeal as a precondition to taking any action against Blue Cross and Blue Shield, either at law or in equity.

Once you have requested this review, you may submit additional information and comments on your Claim to Blue Cross and Blue Shield as long as you do so within 30 days of the date you asked for a review. Also, during this 30 day period, you may review any pertinent documents held by Blue Cross and Blue Shield, if you make an appointment in writing to do so.

Within 60 days of receiving your request for review, Blue Cross and Blue Shield will send you its decision on the Claim. In unusual situations, an additional 60 days may be needed for the review and you will be notified of this during the first 60 day period. In any case, by law, no more than 120 days can be taken for a review, even at your request.

FAILURE TO NOTIFY

The final decision regarding your course of treatment is solely your responsibility and the MSA will not interfere with your relationship with any Provider. However, Blue Cross and Blue Shield has established the MSA program for the specific purpose of assisting you in determining the course of treatment which will maximize your benefits provided under this Policy.

Should you fail to notify the MSA as required in the Preadmission Review provision of this section, you will then be responsible for the first $1,000 of the Hospital or facility charges for an eligible stay in addition to any Deductibles, Copayments and/or Coinsurance applicable to this Policy. This amount shall not be eligible for later consideration as an unreimbursed expense under any benefit section of this Policy nor can it be applied to your out-of-pocket expense limit, if applicable to this Policy.

HOSPITAL BENEFIT SECTION

Expenses for Hospital care are usually the biggest of all health care costs. Your Hospital benefits will help ease the financial burden of these expensive services. This section of your Policy tells you what Hospital services are covered and how much will be paid for each of these services.

As a participant in the Participating Provider Option (PPO) you will receive a directory of Participating (PPO) Hospitals. While there may be changes in the directory listing from time to time, selection of PPO Hospitals by Blue Cross and Blue Shield will continue to be based upon the range of services, geographic location and cost-effectiveness of care. You will receive written notice of any changes to the PPO Hospitals listed in the directory. Although you can continue to go to the Hospital of your choice, your Hospital benefits under this Policy will be greater when you use the services of a PPO Hospital.

The benefits of this section are subject to all of the terms and conditions of this Policy. Your benefits are also subject to the Preexisting Conditions waiting period. Please refer to the DEFINITIONS and EXCLUSIONS sections of this Policy for additional information regarding any limitations and/or special conditions pertaining to your benefits.

In addition, the benefits described in this section will be provided only when you receive services on or after your Coverage Date and they are rendered upon the direction or under the direct care of your Physician. Such services must be Medically Necessary and regularly included in the Provider's charges. In the case of Inpatient services, you must be admitted to the Hospital or other Provider on or after your Coverage Date. This means that benefits will not be provided for an Inpatient stay if you were admitted prior to your Coverage Date.

Remember, whenever the term "you" or "your" is used, we also mean all eligible family members who are covered under Family Coverage.

INPATIENT COVERED SERVICES

Inpatient Hospital Care
You are entitled to benefits for the following services when you are an Inpatient in a Hospital:

1. Bed, board and general nursing care when you are in:
   - — a semi-private room
   - — a private room (at the common semi-private room rate)
   - — an intensive care unit
2. Ancillary services (such as operating rooms, drugs, surgical dressings and lab work)

Preadmission Testing
This is a program in which benefits are provided for preoperative tests given to you as an Outpatient to prepare you for Surgery which you are scheduled to have as an Inpatient (provided that benefits would have been available to you had you received these tests as an Inpatient in a Hospital). Benefits will not be provided if you cancel or postpone the Surgery. These tests are considered part of your Inpatient Hospital surgical stay.

Partial Hospitalization Treatment
Benefits are available for this program only if it is a Blue Cross and Blue Shield approved program. No benefits will be provided for services rendered in a Partial Hospitalization Treatment Program which has not been approved by Blue Cross and Blue Shield.

Coordinated Home Care
Benefits will be provided for services received in a Coordinated Home Care Program.

BENEFIT PAYMENT FOR INPATIENT HOSPITAL COVERED SERVICES

After you have met your Deductible, benefits will be provided at 100% of the Hospital's Eligible Charge when you receive Inpatient Covered Services in a PPO Hospital or in a Plan Program of a PPO Hospital.

When you receive Inpatient Covered Services in a Non-PPO Hospital or in a Plan Program of a Non-PPO Hospital, benefits will be provided at 80% of the Hospital's Eligible Charge, after you have met your Deductible and a separate $300 Inpatient Non-PPO Hospital Deductible.

When you receive Inpatient Covered Services in a Non-Plan Hospital, benefits will be provided at 50% of the Eligible Charge after you have met your Deductible and a separate $300 Inpatient Non-Plan Hospital Deductible.

Emergency Admissions

If you must be hospitalized in a Non-Plan Hospital or Non-PPO Hospital immediately following Emergency Accident Care or Emergency Medical Care, benefits will be provided at the PPO Hospital payment level for that portion of your Inpatient Hospital stay during which your condition is reasonably determined by Blue Cross and Blue Shield to be life threatening and therefore not permitting your safe transfer to a PPO Hospital or Plan Provider.

For that portion of your Inpatient Hospital stay during which your condition is reasonably determined by Blue Cross and Blue Shield not to be life threatening, benefits will be provided at 50% of the Eligible Charge for Covered Services if you are in a Non-Plan Hospital or at 80% of the Eligible Charge if you are in a Non-PPO Hospital.

In order for you to continue to receive benefits at the PPO Hospital payment level following an emergency admission to a Non-Plan or Non-PPO Hospital, you must transfer to a PPO Hospital or other Participating Provider as soon as your condition is no longer life threatening.

TO IDENTIFY NON-PLAN AND PLAN HOSPITALS OR FACILITIES, YOU SHOULD CONTACT BLUE CROSS AND BLUE SHIELD BY CALLING THE CUSTOMER SERVICE TOLL-FREE TELEPHONE NUMBER ON YOUR BLUE CROSS AND BLUE SHIELD IDENTIFICATION CARD.

OUTPATIENT COVERED SERVICES

You are entitled to benefits for the following services when you receive the services from a Hospital (or other specified Provider) as an Outpatient:

1. **Surgery** and any related Diagnostic Service received on the same day as the Surgery.

   In addition to Surgery in a Hospital, benefits will be provided for Outpatient Surgery performed in an Ambulatory Surgical Facility.

2. **Radiation therapy treatments**
3. **Chemotherapy**
4. **Shock therapy**
5. **Renal Dialysis Treatments**—these treatments are eligible for benefits if you receive them in a Hospital, a Dialysis Facility or in your home under the supervision of a Hospital or Dialysis Facility.
6. **Diagnostic Service**—when these services are related to Surgery or Medical Care.
7. **Emergency Accident Care**—treatment must occur within 72 hours of the accident.
8. **Emergency Medical Care**
9. **Mammograms**

BENEFIT PAYMENT FOR OUTPATIENT COVERED SERVICES

After you have met your Deductible, benefits will be provided at:

- 100% of the Eligible Charge for Outpatient Covered Services received in a PPO Hospital, Plan Coordinated Home Care Program, Plan Ambulatory Surgical Facility or Plan Dialysis Facility.
- 80% of the Eligible Charge when you receive Outpatient Covered Services in a Non-PPO Hospital.
- 50% of the Eligible Charge for Outpatient Covered Services received in a Non-Plan Hospital, Non-Plan Ambulatory Surgical Facility or Non-Plan Dialysis Facility.

Benefits for Emergency Accident Care and Emergency Medical Care will be provided at 100% of the Eligible Charge whether rendered in a PPO, Non-PPO or Non-Plan Hospital and are not subject to a Deductible.

WHEN SERVICES ARE NOT AVAILABLE IN A PPO HOSPITAL

If you must receive Hospital Covered Services which Blue Cross and Blue Shield has reasonably determined as unavailable in a PPO Hospital, benefits for the Covered Services you receive in a Non-PPO Hospital will be provided at the payment level described for a PPO Hospital.

HOSPICE CARE PROGRAM

Benefits will be provided for the Hospice Care Program Service described below when these services are rendered to you by a Hospice Care Program Provider. However, for benefits to be available you must have a life expectancy of 6 months or less, as certified by your attending Physician; and you will no longer benefit from standard medical care or have chosen to receive hospice care rather than standard care. Also, a family member or friend must be available to provide custodial type care between visits from Hospice Care Program Providers if hospice is being provided in the home.

The following services are covered under the Hospice Care Program:

1. Coordinated Home Care;
2. Medical supplies and dressings;
3. Medication;
4. Nursing Services - Skilled and non-Skilled;
5. Occupational Therapy;
6. Pain management services;
7. Physical Therapy;
8. Physician visits;
9. Social and spiritual services.

The following services are **not** covered under the Hospice Care Program:

1. Durable Medical Equipment;
2. Home delivered meals;
3. Homemaker services;
4. Respite care;
5. Traditional medical services provided for the direct care of the terminal illness, disease or condition;
6. Transportation, including but not limited, to Ambulance services.

Notwithstanding the above, there may be clinical situations when short episodes of traditional care would be appropriate even when the patient remains in the hospice setting. While these traditional services are not eligible under the Hospice Care Program, they may be Covered Services under other sections of your Policy.

Benefit payment for Covered Services rendered by a Hospice Care Program Provider will be provided at the same level as described for Hospital Covered Services.

PHYSICIAN BENEFIT SECTION

This section of your Policy tells you what services are covered and how much will be paid when you receive care from a Physician.

The benefits of this section are subject to all of the terms and conditions of this Policy. Your benefits are also subject to the Preexisting Conditions waiting period. Please refer to the DEFINITIONS and EXCLUSIONS sections of this Policy for additional information regarding any limitations and/or special conditions pertaining to your benefits.

For benefits to be available, Physician services must be Medically Necessary and you must receive such services on or after your Coverage Date.

Remember, whenever the term "you" or "your" is used, we also mean all eligible family members who are covered under Family Coverage.

COVERED SERVICES

Surgery

Benefits are available for Surgery performed by a Physician, Dentist or Podiatrist. However, for services performed by a Dentist or Podiatrist, benefits are limited to those surgical procedures which may be legally rendered by them and which would be payable under this Policy had they been performed by a Physician. Benefits for oral Surgery are limited to the following services:

1. surgical removal of complete bony impacted teeth;
2. excision of tumors or cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth;
3. surgical procedures to correct accidental injuries of the jaws, cheeks, lips, tongue, roof, and floor of the mouth provided that the injury occurred on or after your Coverage Date;
4. excision of exostoses of the jaws and hard palate (provided that this procedure is not done in preparation for dentures or other prostheses); treatment of fractures of facial bone; external incision and drainage of cellulitis; incision of accessory sinuses, salivary glands or ducts; reduction of dislocation, or excision of, the temporomandibular joints.

The following services are also part of your surgical benefits:

1. Sterilization Procedures (even if they are elective).
2. Anesthesia–if administered at the same time as a covered surgical procedure in a Hospital or Ambulatory Surgical Facility or by a Physician other than the operating surgeon or by a CRNA. However, benefits will be provided for anesthesia services administered by oral and maxillofacial surgeons when such services are rendered in the surgeon's office or Ambulatory Surgical Facility.
3. Assistant Surgeon–that is, a Physician, Dentist or Podiatrist who assists the operating surgeon in performing covered Surgery but only if a Hospital intern or resident is not available for such assistance.

Additional Surgical Opinion

Your coverage includes benefits for an additional surgical opinion following a recommendation for elective Surgery. Your benefits will be limited to one consultation and related Diagnostic Service by a Physician. Benefits for an additional surgical opinion consultation and related Diagnostic Service will be provided at 100% of the Usual and Customary Fee. Your deductible will not apply to this benefit. If you request, benefits will be provided for an additional consultation when the need for Surgery, in your opinion, is not resolved by the first arranged consultation.

Medical Care
Benefits are available for Medical Care visits when:

1. you are an Inpatient in a Hospital, Skilled Nursing Facility or Substance Abuse Treatment Facility or
2. you are a patient in a Partial Hospitalization Treatment Program or Coordinated Home Care Program or
3. you visit your Physician's office or your Physician comes to your home.

No benefits are available under this benefit section for the Outpatient treatment of Mental Illness or Outpatient Substance Abuse Rehabilitaion Treatment. In addition, the Inpatient treatment of Mental Illness and Substance Abuse are subject to the maximums specified in the SPECIAL CONDITIONS section of this Policy.

Consultations
Your coverage includes benefits for consultations when you are an Inpatient in a Hospital or Skilled Nursing Facility. The consultation must be requested by your attending Physician and consist of another Physician's advice in the diagnosis or treatment of a condition which requires special skill or knowledge. Benefits are not available for any consultation done because of Hospital regulations or by a Physician who renders Surgery or Maternity Service during the same admission.

Well Child Care
Benefits will be provided for the following Covered Services rendered to a child under age 16, even if the child is not ill:

- immunizations;
- physical examinations.

Benefits for well child care are limited to a maximum of $500 per child per calendar year.

Mammograms

Shock Therapy Treatments

Radiation Therapy Treatments

Chemotherapy

Diagnostic Service—for those services related to covered Surgery or Medical Care.

Emergency Accident Care—treatment must occur within 72 hours of the accident.

Emergency Medical Care

BENEFIT PAYMENT FOR PHYSICIAN SERVICES
When you receive any of the Covered Services described in this Physician Benefits Section (except as noted below), 80% of the Usual and Customary Fee will be paid after you have met your Deductible.

Benefits for additional surgical opinions and related Diagnostic Services will be provided at 100% of the Usual and Customary Fee and are not subject to a Deductible.

Benefits for Emergency Accident Care and Emergency Medical Care will be provided at 100% of the Usual and Customary Fee and are not subject to a Deductible.

OTHER COVERED SERVICES

COVERED SERVICES

Benefits will be provided under this Policy for the following Other Covered Services:

- Blood and blood components
- Leg, back, arm and neck braces—These braces are covered only when needed because of an illness or injury which occurred after your coverage begun.
- Private Duty Nursing Service—Benefits for Private Duty Nursing Service will be provided to you as an Inpatient in a Hospital or other health care facility only when Blue Cross and Blue Shield determines that the services provided are of such a nature or degree of complexity or quantity that they could not be or are not usually provided by the regular nursing staff of the Hospital or other health care facility. Benefits will be provided to you in your home only when the services are of such a nature that they cannot be provided by non-professional personnel. No benefits will be provided when a nurse ordinarily resides in your home or is a member of your immediate family. Benefits for Private Duty Nursing Service will be limited to a maximum of $1,000 per month.
- Ambulance Transportation—when your condition is such that an ambulance is necessary. Benefits will not be provided for long distance trips or for use of an ambulance because it is more convenient than other transportation.
- Dental accident care—dental services rendered by a Dentist or Physician which are required as the result of an accidental injury. However, these services are covered only if the injury occurred on or after your Coverage Date.
- Allergy shots and allergy surveys
- Oxygen and its administration
- Medical and surgical dressings, supplies, casts and splints
- Durable medical equipment—Benefits will be provided for such things as internal cardiac valves, internal pacemakers, mandibular reconstruction devices (not used primarily to support dental prostheses), bone screws, bolts, nails, plates, and any other internal and permanent devices as reasonably approved by Blue Cross and Blue Shield. Benefits will also be provided for the rental (but not to exceed the total cost of equipment) or purchase of durable medical equipment required for temporary therapeutic use provided that this equipment is primarily and customarily used to serve a medical purpose.
- Prosthetic appliances—Benefits will be provided for prosthetic devices, special appliances and surgical implants required by you for an illness or injury beginning on or after your Coverage Date when:

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

  Benefits will also include adjustments, repair and replacements of covered prosthetic devices, special appliances and surgical implants when required because of wear or change in a patient's condition (excluding dental appliances, replacement of cataract lenses when a prescription change is not required).
- Chiropractic Service—when rendered by a Chiropractor or Physician. Benefits for Chiropractic Service will be limited to a maximum of $1,000 per calendar year.
- Naprapathic Service—Benefits will be provided for Naprapathic Services when rendered by a Naprapath. Benefits for Naprapathic Services will be limited to a maximum of $1,000 per calendar year.
- Optometric services—Benefits will be provided for services which may be legally rendered by an Optometrist, provided that benefits would have been provided had such services been rendered by a Physician.

- Speech Therapy—Benefits will be provided for Speech Therapy when these services are rendered by a licensed speech therapist or speech therapist certified by the American Speech and Hearing Association. Inpatient Speech Therapy benefits will be provided only if Speech Therapy is not the only reason for admission. Benefits for Outpatient Speech Therapy will be limited to a maximum of $3,000 per calendar year.
- Physical Therapy—Benefits will be provided for Physical Therapy when these services are rendered by a Physician or by a registered professional physical therapist under the supervision of a Physician. This therapy must be furnished under a written plan established by a Physician and regularly reviewed by the therapist and the Physician. The plan must be established before treatment is begun and must relate to the type, amount, frequency and duration of therapy and indicate the diagnosis and anticipated goals. Benefits for Outpatient Physical Therapy will be limited to a maximum of $3,000 per calendar year.
- Occupational Therapy—Benefits will be provided for Occupational Therapy when these services are rendered by a Physician or by a registered occupational therapist under the supervision of a Physician. This therapy must be furnished under a written plan established by a Physician and regularly reviewed by the therapist and the Physician. The plan must be established before treatment is begun and must relate to the type, amount, frequency, and duration of therapy and indicate the diagnosis and anticipated goals. Benefits for Outpatient Occupational Therapy will be limited to a maximum of $3,000 per calendar year.
- Cardiac Rehabilitation Services—Benefits will be provided for cardiac rehabilitation services only in Blue Cross and Blue Shield approved programs when these services are rendered to you within a six-month period following an eligible Inpatient Hospital admission for either myocardial infarction, coronary artery bypass Surgery, or percutaneous transluminal coronary angioplasty.

BENEFIT PAYMENT FOR OTHER COVERED SERVICES

After you have met your calendar year Deductible, benefits will be provided at 80% of the Eligible Charge or Usual and Customary Fee for any of the Covered Services described in this section.

SPECIAL CONDITIONS

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

HUMAN ORGAN TRANSPLANTS

Your benefits for certain human organ transplants are the same as your benefits for any other condition. Benefits will be provided only for cornea, kidney, bone marrow, heart valve, muscular-skeletal, parathyroid, heart, lung, heart/lung, liver, pancreas or pancreas/kidney human organ or tissue transplants. Benefits are available to both the recipient and donor of a covered transplant as follows:

— If both the donor and recipient have Blue Cross and Blue Shield coverage each will have their benefits paid by their own Blue Cross and Blue Shield program.

— If you are the recipient of the transplant, and the donor for the transplant has no coverage from any other source, the benefits under this Policy will be provided for both you and the donor. In this case, payments made for the donor will be charged against your benefits.

— If you are the donor for the transplant and no coverage is available to you from any other source, the benefits under this Policy will be provided for you. However, no benefits will be provided for the recipient.

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

— **Whenever a heart, lung, heart/lung, liver, pancreas or pancreas/kidney transplant is recommended by your Physician, you must contact Blue Cross and Blue Shield by telephone before your transplant Surgery has been scheduled. Blue Cross and Blue Shield will furnish you with the names of Hospitals which have Plan approved Human Organ Transplant Programs. No benefits will be provided for heart, lung, heart/lung, liver, pancreas or pancreas/kidney transplants performed at any Hospital that does not have a Plan approved Human Organ Transplant Coverage Program.**

— Your benefits under this coverage will begin no earlier than 5 days prior to the transplant Surgery and shall continue for a period of no longer than 365 days after the transplant Surgery. Benefits will be provided for all Inpatient and Outpatient Covered Services related to the transplant Surgery.

— Benefits will also be provided for the transportation of the donor organ to the location of the transplant Surgery. Benefits will be limited to the transportation of the donor organ in the United States or Canada.

— In addition to the other exclusions of this Policy, benefits will not be provided for the following:

- Cardiac rehabilitation services when not provided to the transplant recipient within 3 days after discharge from a Hospital for transplant Surgery.
- Transportation by air ambulance for the donor or the recipient.
- Travel time and related expenses required by a Provider.
- Drugs which are Investigational.

SKILLED NURSING FACILITY CARE

The following are Covered Services when you receive them in a Skilled Nursing Facility:

(1) Bed, board and general nursing care.

(2) Ancillary services (such as drugs and surgical dressings or supplies).

After you have met your Deductible, benefits will be provided at 100% of the Eligible Charge for Covered Services rendered in a Plan Skilled Nursing Facility and at 50% of the Eligible Charge for Covered Services rendered in a Non-Plan Skilled Nursing Facility.

Benefits will not be provided for services received in an Uncertified Skilled Nursing Facility.

SUBSTANCE ABUSE REHABILITATION TREATMENT AND MENTAL ILLNESS TREATMENT

Substance Abuse Rehabilitation Treatment

Benefits for all of the Covered Services previously described in this Policy are available for Substance Abuse Rehabilitation Treatment. In addition, benefits will be provided if these Covered Services are rendered by a Substance Abuse Treatment Facility and will be provided at the payment levels described later in this benefit section.

Covered Services must be provided in a Blue Cross and Blue Shield approved Substance Abuse Rehabilitation Treatment program. Benefits will not be provided for Substance Abuse Rehabilitation Treatment in programs which have not been approved in writing by Blue Cross and Blue Shield nor will benefits be provided for services in a Non-Plan Substance Abuse Treatment Facility. However, your Substance Abuse Rehabilitation Treatment benefits for the treatment of alcoholism in a non-approved program or Non-Plan facility will be paid at the Non-Plan facility payment level described later in this benefit section.

Mental Illness Treatment

Benefits for all of the Covered Services previously described in this Policy are available for the diagnosis and/or treatment of a Mental Illness. Medical Care for the treatment of a Mental Illness is eligible when rendered by (1) a Physician; or (2) a Psychologist, Clinical Social Worker or a Clinical Professional Counselor working within the scope of their license.

Benefit Payment for Outpatient Treatment

After you have met your Deductible, benefits for Outpatient treatment of Mental Illness will be provided at 50% of the Eligible Charge (in either a PPO, Non-PPO or Non-Plan Hospital) or at 50% of the Usual and Customary Fee.

After you have met your Deductible, benefits for Outpatient Substance Abuse Rehabilitation Treatment will be provided at 50% of the Eligible Charge or at 50% of the Usual and Customary Fee. Benefits will not be provided for Substance Abuse Rehabilitation Treatment in a program which has not been approved by Blue Cross and Blue Shield nor in a Non-Plan Substance Abuse Treatment Facility. However, your Substance Abuse Rehabilitation Treatment benefits for the treatment of alcoholism in a non-approved program or Non-Plan facility are determined differently. Benefits will be provided for the Outpatient treatment of alcoholism in a non-approved program or a Non-Plan facility at 50% of the Eligible Charge after you have met your Deductible.

Your benefits for Outpatient Mental Illness and Outpatient Substance Abuse Rehabilitation Treatment are limited to a combined maximum of $1,000 per calendar year.

Benefit Payment for Inpatient Treatment

After you have met your Deductible and the $300 Non-PPO/Non-Plan Hospital Deductible, if applicable, benefits for Inpatient treatment of Mental Illness and Inpatient Substance Abuse Rehabilitation Treatment will be provided as follows:

- for Inpatient treatment of Mental Illness in a PPO Hospital or in a Non-PPO Hospital, benefits will be provided at 80% of the Eligible Charge for the first 10 days of each admission and at 50% of the Eligible Charge thereafter.
- for Inpatient Substance Abuse Rehabilitation Treatment in a Blue Cross and Blue Shield approved program of a PPO Hospital or a Non-PPO Hospital or in a Plan Substance Abuse Treatment Facility, benefits will be provided at 80% of the Eligible Charge for the first 10 days of each admission and at 50% of the Eligible Charge thereafter.
- for Inpatient treatment of Mental Illness in a Non-Plan Hospital and for Inpatient treatment of alcoholism in a Non-Plan Hospital or Non-Plan Substance Abuse Treatment Facility, benefits will be provided at 50% of the Eligible Charge.

— for Covered Services rendered by a Physician or other professional Provider for the Inpatient treatment of Mental Illness or Inpatient Substance Abuse Rehabilitation Treatment, benefits will be provided at 80% of the Usual and Customary Fee.

Benefits for Inpatient treatment of Mental Illness and Inpatient Substance Abuse Rehabilitation Treatment are limited to a maximum of $10,000 per calendar year.

Inpatient/Outpatient Payment Provisions

None of the charges for the Inpatient and/or Outpatient treatment of Mental Illness or Substance Abuse Rehabilitation Treatment will be included in the calculation of your out-of-pocket expenses.

Benefits for Inpatient and Outpatient treatment of Mental Illness and/or Substance Abuse Rehabilitation Treatment are limited to a combined lifetime maximum of $25,000.

COMPLICATIONS OF PREGNANCY

Benefits will be provided under this Policy for Covered Services received in connection with Complications of Pregnancy.

MASTECTOMY-RELATED SERVICES

Benefits for Covered Services related to mastectomies, including, but not limited to, 1) reconstruction of the breast on which the mastectomy has been performed; 2) surgery and reconstruction of the other breast to produce a symmetrical appearance; and 3) prostheses and physical complications of all stages of the mastectomy including, but not limited to, lymphedemas, are the same as for any other condition.

TEMPOROMANDIBULAR JOINT DYSFUNCTION AND RELATED DISORDERS

Benefits for all of the Covered Services previously described in this Policy are available for the diagnosis and treatment of Temporomandibular Joint Dysfunction and Related Disorders.

Your benefits for the diagnosis and/or treatment of Temporomandibular Joint Dysfunction and Related Disorders are limited to a lifetime maximum of $1,000.

OUTPATIENT PRESCRIPTION DRUG PROGRAM BENEFIT SECTION

When you are being treated for an illness or accident, your Physician may prescribe certain drugs or medicines as part of your treatment. Your coverage includes benefits for drugs and this section of your Policy explains which drugs are covered and the benefits that are available for them. Benefits will be provided only if such drugs are Medically Necessary.

COVERED SERVICES

The drugs for which benefits are available under this Benefit Section are:

- drugs that require, by federal law, a written prescription
- injectable insulin and insulin syringes.

Benefits for these drugs will be provided when:

- you have been given a written prescription for them by your Physician, Dentist, Optometrist or Podiatrist and
- you purchase the drugs from a Pharmacy or from a Physician, Dentist, Optometrist or Podiatrist who regularly dispenses drugs.

Benefits will not be provided for:

- contraceptive drugs, except as specifically mentioned under the Mail Order Prescription Drug Program in this Benefit Section;
- drugs used for cosmetic purposes (including, but not limited to, Retin-A/Tretinoin and Minoxidil/Rogaine);
- any devices or appliances;
- any charges that you may incur for the drugs being administered to you.

In addition, benefits will not be provided for any refills if the prescription is more than one year old.

Benefit Payment for Prescription Drugs

The benefits you receive and the Copayment amount you pay for drugs will differ depending upon whether they are obtained from a Participating Prescription Drug Provider and whether you obtain brand name or generic drugs. "Participating Prescription Drug Provider" means a Pharmacy that has a written agreement with Blue Cross and Blue Shield of Illinois to provide services to you at the time you receive the services.

When you obtain drugs from a Participating Prescription Drug Provider, you must pay a Copayment amount of:

- **$10.00 for each prescription** - for generic drugs.
- **$25.00 for each prescription** - for brand name drugs.

When you obtain drugs from a Participating Prescription Drug Provider, you must pay the Copayment amount described above for each prescription. Benefits will be provided for the remaining Eligible Charge. One prescription means up to a 34 consecutive day supply of a drug. However, for certain maintenance type drugs larger quantities may be obtained. For information on these drugs, contact your Participating Prescription Drug Provider or your local Blue Cross and Blue Shield.

When you obtain drugs from a non-Participating Prescription Drug Provider (other than a Participating Prescription Drug Provider), 75% of the Eligible Charge will be paid minus the Copayment amount.

Mail Order Prescription Drug Program

In addition to the benefits described in this Benefit Section, your coverage includes benefits for maintenance type drugs and certain oral contraceptives obtained through the Mail Order Prescription Drug Program. The Mail Order Prescription Drug Program provides up to a 90-day supply of maintenance prescription medica-

tions. Maintenance medications are drugs used on a continual basis for treatment of chronic health conditions (such as high blood pressure, arthritis or diabetes). For information about this program, contact the Blue Cross and Blue Shield Prescription Drug Inquiry Unit.

When you obtain drugs through the Mail Order Prescription Drug Program, you must pay a Copayment amount of:

- **$10.00 for each prescription** - for generic drugs
- **$25.00 for each prescription** - for brand name drugs

PROGRAM PAYMENT PROVISIONS

LIFETIME MAXIMUM

The total maximum amount of benefits to which you are entitled under this Policy is $5,000,000. This is an individual maximum. There is no family maximum.

As you use your benefits, a certain amount will automatically be restored to your lifetime maximum each year. This amount will be $1,000 or the amount you have received in benefits during that calendar year, whichever is less. Also, your lifetime maximum will be restored in full if you furnish Evidence of Insurability which is satisfactory to Blue Cross and Blue Shield.

OUT-OF-POCKET EXPENSE LIMIT

If, during one calendar year, your out-of-pocket expenses (the amount remaining unpaid for Covered Services after benefits have been provided) equal $1,000, any additional eligible Claims (except for Covered Services excluded below) that you may have during that calendar year will be paid at 100% of the Eligible Charge or Usual and Customary Fee.

The following expenses cannot be used to satisfy the $1,000 limit and the Covered Services listed will not be paid at 100% when the limit has been satisfied:

- the calendar year Deductible.
- the Inpatient Non-PPO/Non-Plan Hospital Deductible.
- Coinsurance applicable to Covered Services received from a Non-Plan Hospital or Non-Plan facility.
- charges that exceed the Eligible Charge or Usual and Customary Fee.
- charges for services that are not Covered Services.
- charges for Covered Services (except for Well Child Care) which have a separate dollar maximum specifically mentioned in this Policy.
- Copayments for noncompliance with the provisions of the Medical Services Advisory Program.
- Copayments and Coinsurance for Outpatient Prescription Drugs.

If you have Family Coverage, your Family Out-of-Pocket Expense Limit is $3,000. If three or more members of your family have eligible out-of-pocket expenses equal to $3,000 during one calendar year, then, for the rest of that year, all other family members will have benefits for Covered Services provided at 100% of the Eligible Charge or Usual and Customary Fee. No more than $1,000 of out-of-pocket expenses from any one family member can be used to satisfy the Family Out-of-Pocket Expense Limit.

EXCLUSIONS—WHAT IS NOT COVERED

— **Hospitalization, services and supplies which are not Medically Necessary.**
No benefits will be provided for services which are not, in the reasonable judgement of Blue Cross and Blue Shield, Medically Necessary. Medically Necessary means that a specific medical, health care or Hospital service is required, in the reasonable medical judgment of Blue Cross and Blue Shield, for the treatment or management of a medical symptom or condition and that the service or care provided is the most efficient and economical service which can safely be provided.

Hospitalization is not Medically Necessary when, in the reasonable medical judgment of Blue Cross and Blue Shield, the medical services provided did not require an acute Hospital Inpatient (overnight) setting, but could have been provided in a Physician's office, the Outpatient Department of a Hospital or some other setting without adversely affecting the patient's condition.

Examples of hospitalization and other health care services and supplies that are not Medically Necessary include:

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

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

Blue Cross and Blue Shield will make the decision whether hospitalization or other health care services or supplies were not Medically Necessary and therefore not eligible for payment under the terms of your Policy. In most instances this decision is made by Blue Cross and Blue Shield AFTER YOU HAVE BEEN HOSPITALIZED OR HAVE RECEIVED OTHER HEALTH CARE SERVICES OR SUPPLIES AND AFTER A CLAIM FOR PAYMENT HAS BEEN SUBMITTED.

The fact that your Physician may prescribe, order, recommend, approve or view hospitalization or other health care services and supplies as Medically Necessary does not make the hospitalization, services or supplies Medically Necessary and does not mean that Blue Cross and Blue Shield will pay the cost of the hospitalization, services or supplies.

If your Claim for benefits is denied on the basis that the services or supplies were not Medically Necessary, and you disagree with Blue Cross and Blue Shield's decision, your policy provides for an appeal of that decision. You must exercise your right to appeal as a precondition to the taking of any further action against Blue Cross and Blue Shield, either at law or in equity. To initiate your appeal, you must give Blue Cross and Blue Shield written notice of your intention to do so within 60 days after you have been notified that your Claim has been denied by writing to:

Claim Review Section
Blue Cross and Blue Shield
Administrator: Hallmark Services Corp.
P.O. Box 2037
Aurora, Illinois 60507-2037

You may furnish or submit any additional documentation which you or your Physician believe appropriate.

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

— Services or supplies that are not specifically mentioned in this Policy.

— Services or supplies for any illness or injury arising out of or in the course of employment for which benefits are available under any Workers' Compensation Law or other similar laws whether or not you make a claim for such compensation or receive such benefits. However, this exclusion shall not apply if you are a corporate officer of any business or enterprise, defined as a "small business" under paragraph (b), Section 3 of the Illinois Small Business Purchasing Act, as amended, and are employed by the corporation and elect to withdraw yourself from the operation of the Illinois Workers' Compensation Act according to the provisions of the Act.

— Services or supplies that are furnished to you by the local, state or federal government and for any services or supplies to the extent payment or benefits are provided or available from the local, state or federal government (for example, Medicare) whether or not that payment or benefits are received, except however, this exclusion shall not be applicable to medical assistance benefits under Article V, VI or VII of the Illinois Public Aid Code (Ill. Rev. Stat. ch. 23 § 1-1 et seq.) or similar Legislation of any state, benefits provided in compliance with the Tax Equity and Fiscal Responsibility Act or as otherwise provided by law.

— Services and supplies for any illness or injury occurring on or after your Coverage Date as a result of war or an act of war.

— Services or supplies that do not meet accepted standards of medical or dental practice; and Investigational Services and Supplies including all related services and supplies.

— Custodial Care Service.

— Routine physical examinations, unless specifically stated in this Policy.

— Services or supplies received during an Inpatient stay when the stay is primarily related to behavioral, social maladjustment, lack of discipline or other antisocial actions which are not specifically the result of Mental Illness.

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

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

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

— Charges for failure to keep a scheduled visit or charges for completion of a Claim form.

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

— Special braces, splints, specialized equipment, appliances, ambulatory apparatus, battery controlled implants, except as specifically mentioned in this Policy.

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

— Eyeglasses, contact lenses or cataract lenses and the examinations for prescribing or fitting of glasses or contact lenses or for determining the refractive state of the eye, except as specifically mentioned in this Policy.

— Treatment of flat foot conditions and the prescription of supportive devices for such conditions and the treatment of subluxations of the foot or routine foot care.

— Immunizations, unless otherwise stated in this Policy.

— Maintenance Occupational Therapy, Maintenance Physical Therapy, and Maintenance Speech Therapy.

— Speech Therapy when rendered for the treatment of psychosocial speech delay, behavioral problems (including impulsive behavior and impulsivity syndrome), attention disorder, conceptual handicap or mental retardation.

— Hearing aids or examinations for the prescription or fitting of hearing aids.

— Diagnostic Service as part of routine physical examinations or check-ups, premarital examinations, determination of the refractive errors of the eyes, auditory problems, surveys, casefinding, research studies, screening, or similar procedures and studies, or tests which are Investigational.

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

— Services and supplies rendered or provided for human organ or tissue transplants other than those specifically named in this Policy.

— Services and supplies rendered or provided for the diagnosis and/or treatment of infertility including, but not limited to, Hospital services, Medical Care, therapeutic injections, fertility and other drugs, Surgery, artificial insemination and all forms of in-vitro fertilization.

— Maternity Service, including related services and supplies.

HOW TO FILE A CLAIM

In order to obtain your benefits under this Policy, it is necessary for a Claim to be filed with Blue Cross and Blue Shield. To file a Claim, usually all you will have to do is show your Blue Cross and Blue Shield ID card to your Hospital or Physician (or other Provider). They will file your Claim for you. Remember, however, it is your responsibility to insure that the necessary Claim information has been provided to Blue Cross and Blue Shield.

Once Blue Cross and Blue Shield receives your Claim, it will be processed and the benefit payment will be sent directly to the Hospital or Physician. You will receive a statement telling you how much was paid. In some cases, Blue Cross and Blue Shield will send the payment directly to you (for example, when you have already paid your Physician).

In certain situations, you will have to file your own Claims. This is primarily true when you are receiving services or supplies from Providers other than a Hospital or Physician. An example would be when you have had ambulance expenses. To file your own Claim, follow these instructions:

1. Complete a Major Medical Claim Form. These are available from Blue Cross and Blue Shield.
2. Attach copies of all bills to be considered for benefits. These bills must include the Provider's name and address, the patient's name, the diagnosis, the date of service and a description of the service and the Claim Charge.
3. Mail the completed Claim Form with attachments to:

   Blue Cross and Blue Shield
   Administrator: Hallmark Services Corp.
   P.O. Box 2037
   Aurora, Illinois 60507-2037

In any case, Claims must be filed with Blue Cross and Blue Shield on or before December 31st of the calendar year following the year in which your Covered Service was rendered. (A Covered Service furnished in the last month of a particular calendar year shall be considered to have been furnished in the succeeding calendar year.)

Should you have any questions about filing Claims, please call Blue Cross and Blue Shield.

TIME OF PAYMENT OF CLAIMS

Blue Cross and Blue Shield will pay all Claims within 30 days of receipt of all information required to process a Claim. In the event that Blue Cross and Blue Shield does not process your Claim within this 30-day period, you shall be entitled to interest, at the rate of 9% per year, from the 30th day after the receipt of all Claim information until the date payment is actually made. However, interest payment will not be made if the amount is $1.00 or less.

CLAIM REVIEW PROCEDURES

If your Claim is denied (in whole or in part), you will receive a written explanation of the denial. Should your Claim be denied (or if 180 days have elapsed since it was filed and you have not received a written decision), you may have your Claim reviewed. To do so, you must request a review no later than 60 days after the denial (or after the end of the 180 day period) by writing to:

Claim Review Section
Blue Cross and Blue Shield
Administrator: Hallmark Services Corp.
P.O. Box 2037
Aurora, Illinois 60507-2037

Once you have requested this review, you may submit additional information and comments on your Claim to Blue Cross and Blue Shield as long as you do so within 30 days of the date you asked for a review. Also, during this 30 day period, you may review any pertinent documents held by Blue Cross and Blue Shield, if you make an appointment in writing to do so.

Within 60 days of receiving your request for review, Blue Cross and Blue Shield will send you its decision on the Claim. In unusual situations, an additional 60 days may be needed for the review and you will be notified of this during the first 60 day period. In any case, by law, no more than 120 days can be taken for a review, even at your request.

You may have someone else represent you in this review procedure as long as you inform Blue Cross and Blue Shield, in writing, of the name of the person who will represent you.

DEPARTMENT OF INSURANCE ADDRESS

In compliance with Section 142(c) of the Illinois Insurance Code, you are hereby given notice of the addresses of the Consumer Divisions of the Department of Insurance. The addresses are:

Illinois Department of Insurance
Consumer Division
100 West Randolph Street
Suite 15-100
Chicago, Illinois 60601

or

Illinois Department of Insurance
Consumer Services Section
320 West Washington Street
Springfield, Illinois 62767

GENERAL PROVISIONS

1. BLUE CROSS AND BLUE SHIELD'S SEPARATE FINANCIAL ARRANGEMENTS WITH PROVIDERS

Blue Cross and Blue Shield hereby informs you that it has contracts with certain Providers ("Plan Providers") in its service area to provide and pay for health care services to all persons entitled to health care benefits under health policies and contracts to which Blue Cross and Blue Shield is a party, including all persons covered under this Policy. Under certain circumstances described in its contracts with Plan Providers, Blue Cross and Blue Shield may:

- receive substantial payments from Plan Providers with respect to services rendered to you for which Blue Cross and Blue Shield was obligated to pay the Plan Provider, or
- pay Plan Providers substantially less than their Claim Charges for services, by discount or otherwise, or
- receive from Plan Providers other substantial allowances under Blue Cross and Blue Shield's contracts with them.

In the case of Hospitals and other facilities, the calculation of any out-of-pocket maximums or any maximum amounts of benefits payable by Blue Cross and Blue Shield under this Policy and the calculation of all required Deductible and Coinsurance amounts payable by you under this Policy shall be based on the Eligible Charge or Provider's Claim Charge for Covered Services rendered to you, reduced by the Average Discount Percentage ("ADP") applicable to your Claim or Claims. Blue Cross and Blue Shield may receive such payments, discounts and/or other allowances during the term of the Policy. You are not entitled to receive any portion of any such payments, discounts and/or other allowances in excess of the ADP.

To help you understand how Blue Cross and Blue Shield's separate financial arrangements with Providers work, please consider the following example:

a. Assume you go into the Hospital for one night and the normal, full amount the Hospital bills for Covered Services is $1,000. How is the $1,000 bill paid?

b. You personally will have to pay the Deductible and Coinsurance amounts set out in your Policy.

c. However, for purposes of calculating your Deductible and Coinsurance amounts, and whether you have reached any out-of-pocket or benefit maximums, the Hospital's Eligible Charge would be reduced by the ADP applicable to your Claim. In our example, if the applicable ADP were 30%, the $1,000 Hospital bill would be reduced by 30% to $700 for purposes of calculating your Deductible and Coinsurance amounts, and whether you have reached any out-of-pocket or benefit maximums.

d. Assuming you have already satisfied your Deductible, you will still have to pay the Coinsurance portion of the $1,000 Hospital bill after it has been reduced by the ADP. In our example, if your Coinsurance obligation is 20%, you personally will have to pay 20% of $700, or $140. You should note that your 20% Coinsurance is based on the full $1,000 Hospital bill, after it is reduced by the applicable ADP.

e. After taking into account the Deductible and Coinsurance amounts, Blue Cross and Blue Shield will satisfy its portion of the Hospital bill. In most cases, Blue Cross and Blue Shield has a contract with Hospitals that allows it to pay less, and requires the Hospital to accept less, than the amount of money Blue Cross and Blue Shield would be required to pay if it did not have a contract with the Hospital.

So, in the example we are using, since the full Hospital bill is $1,000, your Deductible has already been satisfied, and your Coinsurance is $140, then Blue Cross and Blue Shield has to satisfy the rest of the Hospital bill, or $860. Assuming Blue Cross and Blue Shield has a contract with the Hospital, Blue Cross and Blue Shield will usually be able to satisfy the $860 bill that remains after your Coinsurance and Deductible, by paying less than $860 to the Hospital, often substantially less than $860. Blue Cross and Blue Shield receives, and keeps for its own account, the difference between the $860 bill and whatever Blue Cross and Blue Shield ultimately pays under its contracts with Plan Providers, and you are not entitled to any part of these savings.

Other Blue Cross and Blue Shields' Separate Financial Arrangements with Providers

Blue Cross and Blue Shield hereby informs you that other Blue Cross and Blue Shield Plans outside of Illinois ("Host Plans") may have contracts similar to the contracts described above with certain Providers ("Host Plan Providers") in their service area.

When you receive health care services outside of Illinois and from a Provider which does not have a contract with Blue Cross and Blue Shield, the Host Plan will process your Claim in accordance with the Host Plan's applicable contract, if any, with the Host Plan Provider. Coinsurance amounts, Deductibles, out-of-pocket maximums and/or any benefit maximums under this Policy will be calculated on the basis of the Host Plan Provider's Eligible Charge for Covered Services rendered to you or the agreed upon cost between the Host Plan and Blue Cross and Blue Shield for Covered Services that the Host Plan passes to Blue Cross and Blue Shield, whichever is lower.

Often, the agreed upon cost is a simple discount. Sometimes, however, the agreed upon cost may represent either an estimated discount or an average discount received or expected by the Host Plan based on separate financial arrangements or other non-claims transactions with Host Plan Providers.

The estimated or average discount may be adjusted in the future to correct for over or under estimation of past determinations of the agreed upon cost.

In other instances, laws in a small number of states dictate the basis upon which your liability is calculated. When Covered Services are rendered in one of those states, the Coinsurance amount, Deductible, out-of-pocket maximum and/or any benefit maximum will be calculated using the state's statutory method.

2. PAYMENT OF CLAIMS AND ASSIGNMENT OF BENEFITS

a. Under this Policy, Blue Cross and Blue Shield has the right to make any benefit payment either to you or directly to the Provider of the Covered Services. For example, Blue Cross and Blue Shield may pay benefits to you if you receive Covered Services from a Non-Plan Provider. Blue Cross and Blue Shield is specifically authorized by you to determine to whom any benefit payment should be made.

b. Once Covered Services are rendered by a Provider, you have no right to request Blue Cross and Blue Shield not to pay the Claim submitted by such Provider and no such request will be given effect. In addition, Blue Cross and Blue Shield will have no liability to you or any other person because of its rejection of such request.

c. Your claim for benefits under this Policy is expressly non-assignable and non-transferable in whole or in part to any person or entity, including any Provider, at anytime before or after Covered Services are rendered to you. Coverage under this Policy is expressly non-assignable and non-transferable and will be forfeited if you attempt to assign or transfer coverage or aid or attempt to aid any other person in fraudulently obtaining coverage. Any such assignment or transfer of a claim for benefits or coverage shall be null and void.

3. YOUR PROVIDER RELATIONSHIPS

a. The choice of a Provider is solely your choice and Blue Cross and Blue Shield will not interfere with your relationship with any Provider.

b. Blue Cross and Blue Shield does not itself undertake to furnish health care services, but solely to make payments to Providers for the Covered Services received by you. Blue Cross and Blue Shield is not in any event liable for any act or omission of any Provider or the agent or employee of such Provider, including, but not limited to, the failure or refusal to render services to you. Professional services which can only be legally performed by a Provider are not provided by Blue Cross and Blue Shield. Any contractual relationship between a Physician and a Plan Hospital or other Plan Provider shall not be construed to mean that Blue Cross and Blue Shield is providing professional service.

c. The use of an adjective such as Plan or Participating in modifying a Provider shall in no way be construed as a recommendation, referral or any other statement as to the ability or quality of such Provider. In addition, the omission, non-use or non-designation of Plan, Participating or any similar modifier or the use of a term

such as Non-Plan or Non-PPO should not be construed as carrying any statement or inference, negative or positive, as to the skill or quality of such Provider.

4. ENTIRE POLICY; CHANGES

This Policy, including the Addenda and/or Riders, if any, and the individual application of the Insured constitute the entire contract of coverage. All statements made by an Insured shall, in the absence of fraud, be deemed representations and not warranties, and no such statements shall be used in defense to a Claim under this Policy unless it is contained in a written application. No change in this Policy shall be valid until approved by an executive officer of Blue Cross and Blue Shield and unless such approval is endorsed hereon or attached hereto. No agent has authority to change this Policy or to waive any of its provisions. The issuance of this Policy supersedes all previous contracts or policies issued to the Insured by Blue Cross and Blue Shield.

5. NOTICES

Any information or notice which you furnish to Blue Cross and Blue Shield under this Policy must be in writing and sent to Blue Cross and Blue Shield, Administrator: Hallmark Services Corp., P.O. Box 2039, Aurora, Illinois 60507-2039. Any information or notice which Blue Cross and Blue Shield furnishes to you must be in writing and sent to you at your address as it appears on Blue Cross and Blue Shield records.

6. INFORMATION AND RECORDS

You agree that it is your responsibility to insure that any Provider, other Blue Cross and Blue Shield Plan, insurance company, employee benefit association, government body or program, any other person or entity, having knowledge of or records relating to (a) any illness or injury for which a Claim or Claims for benefits are made under this Policy, (b) any medical history which might be pertinent to such illness, injury, Claim or Claims, or (c) any benefits or indemnity on account of such illness or injury or on account of any previous illness or injury which may be pertinent to such Claim or Claims, furnish to Blue Cross and Blue Shield, at any time upon its request, any and all information and records (including copies of records) relating to such illness, injury, Claim or Claims. In addition, Blue Cross and Blue Shield may furnish similar information and records (or copies of records) to other Providers, Blue Cross and Blue Shield Plans, insurance companies, governmental bodies or programs or other entities providing insurance-type benefits requesting the same.

7. LIMITATIONS OF ACTIONS

No legal action may be brought to recover under this Policy, prior to the expiration of 60 days after a Claim has been furnished to Blue Cross and Blue Shield in accordance with the requirements of this Policy. In addition, no such action shall be brought after the expiration of three years after the time a Claim is required to be furnished to Blue Cross and Blue Shield in accordance with the requirements of this Policy.

8. DEATH OF THE INSURED-REFUND OF PREMIUMS

In the event of the death of the Insured (that is, the person to whom this Policy is issued), Blue Cross and Blue Shield shall provide a refund of any unearned premiums assessed following the death of the Insured; provided, however, that a written request for a premium refund is received from the representative of the estate of the Insured or the person or entity so entitled.

9. TIME LIMIT ON CERTAIN DEFENSES

After two years from the date of issue of this Policy no misstatements, except fraudulent misstatements, made by the applicant in the application for such Policy shall be used to void the Policy or to deny a claim for illness or injury beginning after the expiration of such two year period.

No Claim for an illness or injury beginning after 2 years from the date of issue of this Policy shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the effective date of coverage of this Policy.

10. APPLICABLE LAW

This Policy shall be subject to and interpreted by the laws of the State of Illinois.

11. SERVICE MARK REGULATION

You hereby acknowledge your understanding that this Policy constitutes a contract solely between you and Blue Cross and Blue Shield, that Blue Cross and Blue Shield is an independent corporation operating under a license

with the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans (the "Association") permitting us to use the Blue Cross and Blue Shield Service Mark in the state of Illinois, and that we are not contracting as the agent of the Association. You further acknowledge and agree that you have not entered into this Policy based upon representations by any person other than Blue Cross and Blue Shield and that no person, entity, or organization other than Blue Cross and Blue Shield shall be held accountable or liable to you for any of our obligations to you created under this Policy. This paragraph shall not create any additional obligations whatsoever on the part of Blue Cross and Blue Shield other than those obligations created under other provisions of this agreement.

REIMBURSEMENT PROVISION

If you or one of your covered dependents are injured by the act or omission of another person and benefits are provided for Covered Services described in this Policy, you agree:

a. to immediately reimburse Blue Cross and Blue Shield for all Eligible Charges from any and all damages collected from the third party for those same expenses, whether by action at law, settlement or otherwise, as a result of that sickness or injury, in the amount of the total Eligible Charge for Covered Services for which Blue Cross and Blue Shield has provided benefits irrespective of any separate financial arrangement between any Plan Provider and Blue Cross and Blue Shield.

b. that Blue Cross and Blue Shield will have a lien to the extent of the total Eligible Charge for Covered Services provided. Such lien may be filed with the person whose act caused the injury, the person's agent or a court having jurisdiction in the matter.

It is your responsibility to furnish any information, assistance or provide any documents that Blue Cross and Blue Shield may request in order to obtain its rights under this provision. (See provisions of this Policy regarding "Blue Cross and Blue Shield's Separate Financial Arrangements with Providers.")

BlueCross BlueShield of Illinois

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

RIDER TO THE POLICY

The Policy, to which this Rider is attached and becomes a part, is hereby amended as stated below.

DEFINITIONS SECTION

The definition for Eligible Charge and Usual and Customary Fee are deleted and replaced with the following:

ELIGIBLE CHARGE.....means (a) in the case of a Provider which has a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and/or Blue Shield Plan to provide care to you at the time Covered Services are rendered, such Provider's Claim Charge for Covered Services and (b) in the case of a Provider which does not have a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and/or Blue Shield Plan to provide care to you at the time Covered Services are rendered, will be the lesser of:

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

(ii) the Blue Cross and Blue Shield of Illinois non-contracting Eligible Charge. Except as otherwise provided in this section, the non-contracting Eligible Charge is developed from base Medicare reimbursements and represents approximately 100% of the base Medicare reimbursement rate and will exclude any Medicare adjustment(s) which is/are based on information on the Claim.

Notwithstanding the preceding sentence, the non-contracting Eligible Charge for Coordinated Home Care Program Covered Services will be 50% of the Non-Participating or Non-Plan Provider's standard billed charge for such Covered Services.

When a Medicare reimbursement rate is not available for a Covered Service or is unable to be determined on the information submitted on the Claim, the Eligible Charge for Non-Participating or Non-Plan Providers will be 50% of the Non-Participating or Non-Plan Provider's standard billed charge for such Covered Service.

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

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

USUAL AND CUSTOMARY FEE.....means for purposes of this benefit plan, the Usual and Customary Charge for Covered Services will be the lesser of: (i) the Provider's billed charges, or; (ii) Blue Cross and Blue Shield of Illinois' Usual and Customary Charge. Except as otherwise provided in this section, Usual and Customary Charge is developed from base Medicare reimbursements and represents approximately 100% of the base Medicare reimbursement rate and will exclude any Medicare adjustments(s) which is/are based on information on the Claim.

Notwithstanding the preceding sentence, the Usual and Customary Charge for Home Health Covered Services will be 50% of the non-contracted Provider's standard billed charge for such Covered Service.

When a Medicare reimbursement rate is not available for a Covered Service or is unable to be determined based on the information submitted on the Claim, the Usual and Customary Charge will be 50% of the Provider's standard billed chare for such Covered Service.

Blue Cross and Blue Shield of Illinois will utilize the same Claim processing rules and/or edits that it utilizes in processing all professional Provider Claims which may also alter the Usual and Customary Charge for a particular service. In the event Blue Cross and Blue Shield of Illinois does not have any claim edits or rules, Blue Cross and Blue Shield of Illinois may utilize the Medicare claim rules or edits that are used by Medicare in processing the Claims. The Usual and Customary Charge will not include any additional payments that may be permitted under the Medicare laws or regulations which are not directly attributable to a specific Claim, including, but not limited to, disproportionate share payments and graduate medical education payments.

In the event the Usual and Customary Charge does not equate to the Provider's billed charges, you will be responsible for the difference, along with any applicable Copayment, Coinsurance and deductible amount. This difference may be considerable.

Except as amended by this Rider, all other terms, conditions, limitations and exclusions of the Policy, to which this Rider is attached, will remain in full force and effect.

Attest:

Health Care Service Corporation
a Mutual Legal Reserve Company
(Blue Cross and Blue Shield of Illinois)

Deborah Dorman-Rodriguez
Secretary

Patricia A. Heminway Hall
President

RIDER TO THE POLICY
REGARDING AUTISM SPECTRUM DISORDER(S), HABILITATIVE CARE, AND MAMMOGRAMS

The Policy, to which this Rider is attached and becomes a part, is hereby amended as stated below.

A. DEFINITIONS SECTION

The following definitions are added to the **DEFINITIONS SECTION** of your Policy:

AUTISM SPECTRUM DISORDER(S).....means pervasive developmental disorders as defined in the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders*, including autism, Asperger's disorder and pervasive developmental disorders not otherwise specified.

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

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

HABILITATIVE SERVICES.....means Occupational Therapy, Physical Therapy, Speech Therapy, and other services prescribed by a Physician pursuant to a treatment plan to enhance the ability of a child to function with a Congenital, Genetic, or Early Acquired Disorder.

B. HOSPITAL BENEFIT SECTION

The Mammograms provision under **Outpatient Covered Services** is replaced with the following:

Mammograms—Benefits for routine mammograms will be provided at the benefit payment level described in the SPECIAL CONDITIONS AND PAYMENTS section of this Policy. Benefits for mammograms, other than routine, will be provided at the same payment level as Outpatient Diagnostic Service.

C. PHYSICIAN BENEFIT SECTION

The Mammograms provision under **COVERED SERVICES** is replaced with the following:

Mammograms—Benefits for routine mammograms will be provided at the benefit payment level described in the SPECIAL CONDITIONS AND PAYMENTS section of this Policy. Benefits for mammograms, other than routine, will be provided at the same payment level as Outpatient Diagnostic Service.

D. SPECIAL CONDITIONS AND PAYMENTS

1. The following provisions are added to the **SPECIAL CONDITIONS** section of your Policy:

   a. **AUTISM SPECTRUM DISORDER(S)**

   Your benefits for the diagnosis and treatment of Autism Spectrum Disorder(s), for persons under 21 years of age, are the same as your benefits for any other condition. Treatment for Autism Spectrum Disorder(s) shall include the following care when prescribed, provided or ordered for an individual diagnosed with an Autism Spectrum Disorder by (A) a Physician or a Psychologist who has determined that such care is medically necessary, or (B) a certified, registered or licensed health care professional with expertise in treating Autism Spectrum Disorder(s) and when such care is determined to be medically necessary and ordered by a Physician or a Psychologist:

   - psychiatric care, including diagnostic services;
   - psychological assessments and treatments;
   - habilitative or rehabilitative treatments;
   - therapeutic care, including behavioral Speech, Occupational and Physical Therapies that provide treatment in the following areas: a) self care and feeding, b) pragmatic, receptive and

expressive language, c) cognitive functioning, d) applied behavior analysis (ABA), intervention and modification, e) motor planning and f) sensory processing.

When you receive Covered Services for Autism Spectrum Disorder(s) that are not otherwise covered as a benefit in this Policy, benefits will be limited to a maximum of $36,000. After December 30, 2009, the maximum amount will be adjusted annually for inflation using the Medical Care Component of the United States Department of Labor Consumer Price Index for all Urban Consumers.

b. **HABILITATIVE SERVICES**

Your benefits for Habilitative Services for persons under 19 years of age with a Congenital, Genetic, or Early Acquired Disorder are the same as your benefits for any other condition if all of the following conditions are met:

- A Physician has diagnosed the Congenital, Genetic, or Early Acquired Disorder; and
- Treatment is administered by a licensed speech-language pathologist, Audiologist, Occupational Therapist, Physical Therapist, Physician, licensed nurse, Optometrist, licensed nutritionist, Clinical Social Worker, or Psychologist upon the referral of a Physician; and
- Treatment must be Medically Necessary and therapeutic and not Investigational.

c. **ROUTINE MAMMOGRAMS**

Benefits will be provided for routine mammograms for all women age 35 years and older. A routine mammogram is an x-ray or digital examination of the breast for the presence of breast cancer, even if no symptoms are present. Benefits for routine mammograms will be provided as follows:

— one baseline mammogram for women age 35-39

— an annual mammogram for women age 40 or older

Benefits for routine mammograms will be provided for women under age 40 who have a family history of breast cancer or other risk factors at the age and intervals considered medically necessary by their Physician.

If a routine mammogram reveals heterogeneous or dense breast tissue, benefits will be provided for a comprehensive ultrasound screening of an entire breast or breasts, when determined to be medically necessary by your Physician.

Benefits for routine mammograms when rendered by a Participating Provider will be provided at 100% of the Eligible Charge or Maximum Allowance whether or not you have met your program deductible. Benefits for routine mammograms will not be subject to the Participating Provider office visit Copayment.

Benefits for routine mammograms will not be subject to any benefit period maximum or lifetime maximum when Covered Services are rendered by a Participating Provider.

Benefits for routine mammograms, when rendered by a Non-Participating Provider, will be provided at the Hospital or Physician payment level for Non-Participating Providers specified on the Schedule Page. Benefits will be subject to the program deductible.

2. The description for routine diagnostic tests in the **WELLNESS CARE** provision is replaced with the following:

   Routine diagnostic tests (other than routine mammograms), ordered or received on the same day as the examination. Benefits for routine mammograms will be provided at the benefit payment level described in the **ROUTINE MAMMOGRAMS** provision in this section of the Policy.

3. The last sentence in the **WELLNESS CARE** provision is replaced with the following:

   The following Covered Services are not subject to the wellness care benefit maximum: colorectal cancer screening, clinical breast examinations, human papillomavirus vaccine, and shingles vaccine.

E. EXCLUSIONS-WHAT IS NOT COVERED

1. The exclusion for **Investigational Services and Supplies** is deleted and replaced with the following:

   Investigational Services and Supplies and all related services and supplies, except as may be provided under your Policy for a) the cost of routine patient care associated with Investigational cancer treatment, if those services or supplies would otherwise be covered under the Policy if not provided in connection with an approved clinical trial program and b) applied behavior analysis used for the treatment of Autism Spectrum Disorder(s).

2. The exclusion for **Speech Therapy** is deleted and replaced with the following:

   Speech Therapy when rendered for the treatment of psychosocial speech delay, behavioral problems (including impulsive behavior and impulsivity syndrome), attention disorder, conceptual handicap or mental retardation, except as may be provided under your Policy for Autism Spectrum Disorder(s).

3. The following exclusion is added:

   Habilitative Services that are solely educational in nature or otherwise paid under State or Federal law for purely educational services.

Except as amended by this Rider, all other terms, conditions, limitations and exclusions of the Policy, to which this Rider is attached, will remain in full force and effect.

Attest:

Health Care Service Corporation
a Mutual Legal Reserve Company
(Blue Cross and Blue Shield of Illinois)

Secretary

President

RIDER TO THE POLICY REGARDING DEPENDENT LIMITING AGE

The Policy to which this Rider is attached and becomes a part, is amended as stated below.

COVERAGE AND PREMIUM INFORMATION

The dependent limiting age under the **FAMILY COVERAGE** provision is revised to read as follows:

If you have Family Coverage, your health care expenses and those of your enrolled spouse and your (or your spouse's) enrolled unmarried children who are under age 26 will be covered. Coverage for unmarried children will end on the last day of the period for which the premium has been paid, after the child's 26th birthday. Coverage for children who marry ends on the date of their marriage.

Enrolled unmarried children will be covered up to age 30 if they:

- live within the state of Illinois; and
- have served as an active or reserve member of any branch of the Armed Forces of the United States; and
- have received a release or discharge other than a dishonorable discharge.

Except as amended by this Rider, all other terms, conditions, limitations and exclusions of the Policy to which this Rider is attached will remain in full force and effect.

Attest:

Health Care Service Corporation
a Mutual Legal Reserve Company
(Blue Cross and Blue Shield of Illinois)

Deborah Dorman-Rodriguez
Secretary

Patricia A. Hemingway Hall
President and CEO

DB-A64 HCSC

OMNIBUS RIDER TO THE POLICY

The Policy, to which this Rider is attached and becomes a part, is hereby amended as stated below.

A. PHYSICIAN BENEFIT SECTION

The following provisions are added to the list of **COVERED SERVICES:**

1. **Clinical Breast Examinations**—Benefits will be provided for clinical breast examinations when performed by a Physician, [Advanced Practice Nurse] or a Physician Assistant working under the direct supervision of a Physician.

   If your Policy includes benefits for Wellness Care, the following applies:

   Benefits for clinical breast examination will be provided at the benefit payment level described in the Wellness Care provision of this Policy.

2. **Human Papillomavirus Vaccine**—Benefits will be provided for a human papillomavirus (HPV) vaccine approved by the federal Food and Drug Administration. [Benefits will be provided at the benefit payment level for immunizations described in the Well Child Care provision of this Policy.] If you purchase the vaccine at a Pharmacy, benefits will be provided at the benefit payment level for Other Covered Services described in the OTHER COVERED SERVICES section of this Policy.

   If your Policy includes benefits for Wellness Care, the following applies:

   Benefits will be provided at the benefit payment level for immunizations described in the Wellness Care provision of this Policy.

3. **Amino Acid-Based Elemental Formulas**—Benefits will be provided for amino acid-based elemental formulas for the diagnosis and treatment of eosinophilic disorders or short-bowel syndrome, when the prescribing Physician has issued a written order stating that the amino acid-based elemental formula is medically necessary. If you purchase the formula at a Pharmacy, benefits will be provided at the benefit payment level for Other Covered Services described in the OTHER COVERED SERVICES section of this Policy.

B. SPECIAL CONDITIONS

If your Policy includes benefits for Wellness Care, the following provision is added as the last paragraph under WELLNESS CARE section of your Policy:

The following Covered Services are not subject to the wellness care benefit maximum: colorectal cancer screening, clinical breast examinations and human papillomavirus vaccine.

Except as amended by this Rider, all other terms, conditions, limitations and exclusions of the Policy, to which this Rider is attached, will remain in full force and effect.

Attest:

Health Care Service Corporation
a Mutual Legal Reserve Company
(Blue Cross and Blue Shield of Illinois)

Deborah Dorman-Rodriguez
Secretary

Patricia A. Hemingway Hall
President and CEO

DB-A65 HCSC

OMNIBUS RIDER TO THE POLICY

The Policy, to which this Rider is attached and becomes a part, is hereby amended as stated below.

A. PHYSICIAN BENEFIT SECTION

The following provision is added to the list of COVERED SERVICES:

Shingles Vaccine—Benefits will be provided for a shingles vaccine approved by the federal Food and Drug Administration.

If your Policy includes benefits for Wellness Care, the following applies:

Benefits will be provided at the benefit payment level described in the Wellness Care provision of this Policy.

B. SPECIAL CONDITIONS

If your Policy includes benefits for Wellness Care, the last paragraph under the WELLNESS CARE section of your Policy is deleted and replaced with the following:

The following Covered Services are not subject to the wellness care benefit maximum: colorectal cancer screening, clinical breast examinations, human papillomavirus vaccine and shingles vaccine.

Except as amended by this Rider, all other terms, conditions, limitations and exclusions of the Policy, to which this Rider is attached, will remain in full force and effect.

Attest:

Health Care Service Corporation
a Mutual Legal Reserve Company
(Blue Cross and Blue Shield of Illinois)

Deborah Dorman-Rodriguez
Secretary

Patricia A. Hemingway Hall
President and CEO

DB–A66 HCSC

OMNIBUS RIDER TO THE POLICY

The Policy, to which this Rider is attached and becomes a part, is hereby amended as stated below.

A. EXCLUSIONS–WHAT IS NOT COVERED

The paragraph which begins with "If your Claim for benefits is denied..." of this section is hereby deleted in its entirety and replaced with the following:

If your Claim for benefits is denied on the basis that the services or supplies were not Medically Necessary, and you disagree with Blue Cross and Blue Shield's decision, your policy provides for an appeal of that decision. You must exercise your right to appeal as a precondition to the taking of any further action against Blue Cross and Blue Shield, either at law or in equity. To initiate your appeal, you must give Blue Cross and Blue Shield written notice of your intention to do so within 60 days after you have been notified that your Claim has been denied by writing to:

Claim Review Section
Blue Cross and Blue Shield
Administrator: Hallmark Services Corp.
P.O. Box 3235
Naperville, Illinois 60566-7235

You may furnish or submit any additional documentation which you or your Physician believe appropriate.

B. HOW TO FILE A CLAIM

The third bullet under the paragraph which begins "In certain situations, you will have to file your own Claims" of this section is deleted in its entirety and replaced with the following:

3. Mail the completed Claim Form with attachments to:

Blue Cross and Blue Shield
Administrator: Hallmark Services Corp.
P.O. Box 3235
Naperville, Illinois 60566-7235

The **CLAIM REVIEW PROCEDURES** of this section is hereby deleted in its entirety and replaced with the following:

If your Claim is denied (in whole or in part), you will receive a written explanation of the denial. Should your Claim be denied (or if 180 days have elapsed since it was filed and you have not received a written decision), you may have your Claim reviewed. To do so, you must request a review no later than 60 days after the denial (or after the end of the 180 day period) by writing to:

Claim Review Section
Blue Cross and Blue Shield
Administrator: Hallmark Services Corp.
P.O. Box 3235
Naperville, Illinois 60566-7235

C. GENERAL PROVISIONS

The **NOTICES** provision of this section is hereby deleted in its entirety and replaced with the following:

Any information or notice which you furnish to Blue Cross and Blue Shield under this Policy must be in writing and sent to Blue Cross and Blue Shield, Administrator: Hallmark Services Corp., P.O. Box 3235, Naperville, Illinois 60566-7235. Any information or notice which Blue Cross and Blue Shield furnishes to you must be in writing and sent to you at your address as it appears on Blue Cross and Blue Shield's records or, if applicable, in the case of a medical child support court order, to the designated representative as it appears on Blue Cross and Blue Shield's records.

Except as amended by this Rider, all other terms, conditions, limitations and exclusions of the Policy, to which this Rider is attached, will remain in full force and effect.

Attest:

Health Care Service Corporation
a Mutual Legal Reserve Company
(Blue Cross and Blue Shield of Illinois)

Patricia A. Hemingway Hall

Patricia A. Hemingway Hall
President and CEO

Deborah Dorman-Rodriguez

Deborah Dorman-Rodriguez
Secretary

DB-A69 HCSC

OMNIBUS RIDER TO THE POLICY

The Policy, to which this Rider is attached and becomes a part, is hereby amended as stated below.

DEFINITIONS SECTION

The definition of **Eligible Charge** is deleted and replaced with the following:

ELIGIBLE CHARGE.....means (a) in the case of a Provider which has a written agreement with Blue Cross and Blue Shield to provide care to you at the time Covered Services are rendered, such Provider's Claim Charge for Covered Services and (b) in the case of a Provider which does not have a written agreement with Blue Cross and Blue Shield to provide care to you at the time Covered Services are rendered, the amount for Covered Services determined by Blue Cross and Blue Shield based on the following order:

(i) the amount that Centers for Medicare and Medicaid ("CMS") reimburses the Hospitals or facilities in similar geographic areas for the same or similar services rendered to members in the Medicare program; or

(ii) the charge which is within the range of charges other similar Hospitals or facilities in similar geographic areas charge their patients for the same or similar services; or

(iii) the charge which the particular Hospital or facility usually charges its patients for Covered Services.

Except as amended by this Rider, all other terms, conditions, limitations and exclusions of the Policy, to which this Rider is attached, will remain in full force and effect.

Attest:

Health Care Service Corporation
a Mutual Legal Reserve Company
(Blue Cross and Blue Shield of Illinois)

Deborah Dorman-Rodriguez

Deborah Dorman-Rodriguez
Secrectary

Patricia A Hemingway Hall

Patricia A. Hemingway Hall
President and CEO

OMNIBUS RIDER TO THE POLICY

The Policy, to which this Rider is attached and becomes a part, is hereby amended as stated below.

A. GUARANTEED RENEWABILITY

Coverage under this Policy will be terminated for nonpayment of premiums. In addition, Blue Cross and Blue Shield may terminate or refuse to renew this Policy only for the following reasons:

1. If every Policy that bears this Policy form number* is not renewed. If this should occur:
   a. Blue Cross and Blue Shield will give you at least 90 days prior to written notice.
   b. You may convert to any other individual policy Blue Cross and Blue Shield offers to the individual market.
2. In the event of fraud or an intentional misrepresentation of material fact under the terms of this Policy. In this case, Blue Cross and Blue Shield will give you at least thirty (30) days prior written notice
3. If you no longer reside, live or work in an area for which Blue Cross and Blue Shield is authorized to do business.

Blue Cross and Blue Shield will never terminate or refuse to renew this Policy because of the condition of your health. Blue Cross and Blue Shield may uniformly modify coverage provided by every Policy which bears this Policy form number only on the coverage Renewal Date.

B. DEFINITIONS SECTION

The following will be added to the DEFINITIONS SECTION:

BENEFIT PERIOD.....means a period of one year which begins on January 1st of each year. When you first enroll under this coverage, your first Benefit Period begins on your Coverage Date, and ends on the first December 31st following that date.

RENEWAL DATE.....means January 1st of each year when your health coverage under this Policy renews for another Benefit Period.

Except as amended by this Rider, all other terms, conditions, limitations and exclusions of the Policy, to which this Rider is attached, will remain in full force and effect.

Attest:

Health Care Service Corporation
a Mutual Legal Reserve Company
(Blue Cross and Blue Shield of Illinois)

Raymond F. McCaskey
President

Thomas C. Lubben
Secretary

*DB–10 HCSC, DB-11 HCSC, DB-12 HCSC, DB-13 HCSC, DB-14 HCSC, DB-15 HCSC, DB-16 HCSC, DB-18 HCSC, DB-19 HCSC, DB-20 HCSC, DB-21 HCSC, DB-22 HCSC, DB-23 HCSC, DB-24 HCSC, DB-26 HCSC, DB-27 HCSC, DB-34 HCSC, DB-40 HCSC, DB-41 HCSC, DB-42 HCSC, DB-43 HCSC, DB-44 HCSC, DB-45 HCSC, DB-46 HCSC, DB-47 HCSC, DB-48 HCSC, DB-49 HCSC, DB-50 HCSC, DB-51 HCSC, DB-53 HCSC

OMNIBUS RIDER TO THE POLICY

The Policy, to which this Rider is attached and becomes a part, is hereby amended as stated below.

A. HOSPITAL BENEFIT SECTION

The following provision is added to the list of Outpatient Covered Services:

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

B. PHYSICIAN BENEFIT SECTION

1. The following provision is added to the list of Covered Services:

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

2. The **Assistant Surgeon** provision is deleted and replaced with the following:

   Assist at Surgery—when performed by a Physician, Dentist or Podiatrist who assists the operating surgeon in performing covered Surgery in a Hospital or Ambulatory Surgical Facility. In addition, benefits will be provided for assist at Surgery when performed by a Registered Surgical Assistant or an Advanced Practice Nurse. Benefits will also be provided for assist at Surgery performed by a Physician Assistant under the direct supervision of a Physician, Dentist or Podiatrist.

3. If your Policy has a **Muscle Manipulations** provision, it is deleted and replaced with the following:

   Chiropractic and Osteopathic Manipulation

   Benefits will be provided for manipulation or adjustment of osseous or articular structures, commonly referred to as chiropractic and osteopathic manipulation, when performed by a person licensed to perform such procedures. Your benefits for chiropractic and osteopathic manipulation will be limited to the maximum stated in your Policy.

4. If your Policy has a **Physical Therapy** provision, the following sentence is added:

   Benefits will also be provided for preventive or Maintenance Physical Therapy when prescribed for persons affected by multiple sclerosis subject to the Outpatient Physical Therapy benefit maximum.

C. OTHER COVERED SERVICES

Amino acid-based formulas—Benefits will be provided for amino acid–based formulas for the diagnosis and treatment of eosinophilic disorders or short–bowel syndrome, when the prescribing Physician has issued a written order stating that the amino acid–based elemental formula is medically necessary.

D. EXCLUSIONS – WHAT IS NOT COVERED

If your Policy has an exclusion for **Maintenance Physical Therapy,** it is deleted and replaced with the following:

Maintenance Occupational Therapy, Maintenance Physical Therapy and Maintenance Speech Therapy, except as specifically mentioned in this Policy.

E. HOW TO FILE A CLAIM

The **Department of Insurance Address** provision is deleted and replaced with the following:

In compliance with Section 142(c) of the Illinois Insurance Code, you are hereby given notice of the addresses of the Consumer Divisions of the Illinois Department of Financial and Professional Regulations, Division of Insurance. The addresses are:

Illinois Department of Financial and
Professional Regulation, Division of Insurance
Consumer Division
100 West Randolph Street
Suite 15-100
Chicago, Illinois 60601

or

Illinois Department of Financial and
Professional Regulation, Division of Insurance
Consumer Services Section
320 West Washington Street
Springfield, Illinois 62767

Except as amended by this Rider, all other terms, conditions, limitations and exclusions of the Policy, to which this Rider is attached, will remain in full force and effect.

Attest:

Health Care Service Corporation
a Mutual Legal Reserve Company
(Blue Cross and Blue Shield of Illinois)

Raymond F. McCaskey
President

Thomas C. Lubben
Secretary

BlueCross BlueShield of Illinois

To Use or Disclose Protected Health Information (PHI)

Standard Authorization Form

I. Individual (Name and information of person whose protected health information is being disclosed):

Name			Date of Birth
Group #	Identification/Subscriber #		Social Security Number
Address	City	State	ZIP
Area Code & Telephone Number			

II. Authorization and Purpose:

I request and authorize Blue Cross and Blue Shield of Illinois to disclose my protected health information as described below. **I understand that if the person/organization authorized to receive and use the information is not a health plan or health care provider, the disclosed information may no longer be protected by federal privacy regulations.**

Persons/Organizations authorized to receive your information		Relationship	Purpose
Address	City	State	ZIP

III. Specific Description of Information to be Used or Disclosed

(Please complete Parts A and B in this Section) **This Authorization CANNOT be used to disclose Psychotherapy Notes.**

A. Release of *Sensitive* Protected Health Information Under State Law

You *must* check "yes" or "no" if you authorize the release of medical information, test results, records or communications specific to
(note: "yes" means this information is included in the categories you designate in Part B below):

- Human Immunodeficiency Virus (HIV) or HIV/Acquired Immune Deficiency Syndrome;
- Sexually transmitted or communicable diseases (includes hepatitis, as well as venereal diseases);
- Drug, alcohol or substance abuse;
- Mental health or developmental disabilities (including mental retardation or similar disabilities, for example, those attributable to cerebral palsy, autism or neurological dysfunctions); and
- Genetic testing.

Yes ☐
No ☐

B. Release of Protected Health Information *(check one or more)*

		Dates of Services From:	To:
☐ **Health Plan Benefit Information**	Includes information contained in your benefit booklet (i.e., copayments, coinsurance, eligibility and other benefit information).		
☐ **Claims**	Includes information related to payment of your claims for service you received, including pertinent information located on a claim form (i.e., billed amount, general procedure descriptions, claim payment or denial reasons, etc.).		
☐ **Service Determination Information**	Includes any information related to pre-service, concurrent and post-service decisions.		
☐ **Premium**	Includes information related to billing cycles, bank draft changes, etc.		
☐ **Services from (provider or supplier)**	Provider name: _____ (Includes information related to services rendered by a specific provider or supplier.)		
☐ **Other**	_____ (Specify other information that is not listed in one of the categories above.)		

IV. Expiration and Revocation

Expiration: This authorization will expire on (must choose one):

☐ One year from the date it is signed ☐ Other (insert date or event): _____

Right to Revoke: I understand that I may revoke this authorization at any time by giving written notice to the address listed at the bottom of this form. **I understand that revocation of this authorization will not affect any action the above named entity took in reliance on this authorization before the above named entity received my written notice of revocation.**

V. Signature (this document must be signed by the individual, parent of minor child or the individual's personal representative)

I understand that this authorization is voluntary and that the health plan cannot condition my eligibility for benefits, treatment, enrollment or payment of claims on the signing of this authorization. I understand that if I am signing on behalf of a minor child, this authorization will expire upon the child reaching the age of 18, unless there is proof of legal guardianship.

_____ _____

Signature Date: month/day/year

If you are signing as a Power of Attorney, Legal Guardian, Executor or Administrator, complete the following and attach a copy of the Legal documents. You do NOT have to attach copies of documents if they are already on file with Blue Cross and Blue Shield of Illinois.

_____ _____

Personal Representative's Name Relationship to Individual

_____ _____ _____ _____

Personal Representative's Address City State ZIP

_____

Personal Representative's Area Code & Telephone Number

BEFORE RETURNING YOU SHOULD KEEP A COPY FOR YOUR RECORDS BY EITHER:

1. MAKING A PHOTOCOPY OF THIS SIGNED AUTHORIZATION; OR
2. COMPLETING AND SIGNING THE DUPLICATE AUTHORIZATION FORM YOU RECEIVED OR PRINTED

Mail your completed signed authorization to:
Blue Cross and Blue Shield of Illinois
P.O. Box 3238
Naperville, IL 60566-7238

If you need assistance completing the form, please contact our Member Service Department at 1-800-538-8833.

BlueCross BlueShield of Illinois

Value-added programs, tools and services are just another advantage of being a Blue Cross and Blue Shield of Illinois (BCBSIL) member.

Blue Access for Members℠*

Your gateway to health information

It's easy to register and find what you need at ***bcbsil.com/member.***

When it comes to managing your health information, it's "easy does it" with our Blue Access for Members (BAM) member site. BAM gives you important health and benefits information that you can manage in one convenient place online.

Go to bcbsil.com, click "Log In" and register to access:

- your personal health history
- benefits highlights, claims, explanations of benefits and forms
- health and wellness resources
- special member discounts and programs

Blue Access Mobile℠

With Blue Access Mobile, you have access to real-time claims status, ID cards and coverage details. Now you can get that information while on the go because BAM is mobile!

** Blue Access for Members is not available on child only policies.*

Provider Finder

Easily search for physicians, specialists and hospitals

It's easy to find physicians, specialists and hospitals with the online Provider Finder. Follow these three steps:

1. Visit bcbsil.com
2. Click Provider Finder
3. Search by network, doctor, hospital or area to find the most up-to-date listing of health care providers

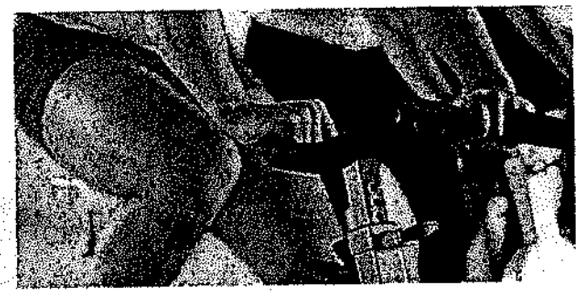
Download the free Provider Finder® App for Android or iPhone

In addition to finding a provider when you're on the go, this app can perform a GPS search and get directions to the provider's location.

31613.0413

Well onTarget℠

Motivation and guidance on the path to health and wellness



The Well onTarget program offers an expanded array of personalized tools and resources designed to plan, engage, motivate, sustain and measure, with the end goal of delivering the best wellness experience to members.

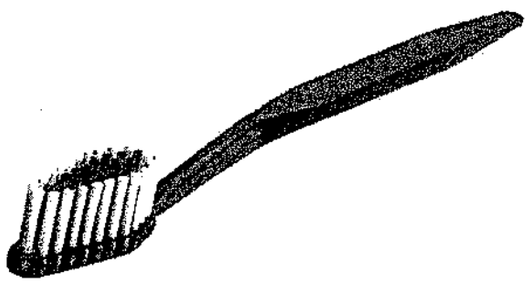
Well onTarget includes wellness programs such as:

- Onmyway™ health assessment
- Health and wellness content
- Liveon wellness member portal
- Fitness program and incentives
- Onmytime self-directed courses

Learn more at wellontarget.com.

BlueCare® Dental PPO

For individuals and families



Something to smile about...
Maximum dental coverage that doesn't take a big bite out of your wallet!

You'll get preventive dental coverage on day one – with no deductible required – for checkups, cleanings and other preventive services. You can choose any dentist you want, with no referrals needed.

By choosing the BlueCare Dental PPO plan from BCBSIL, you can be certain that the savings will add up. In fact, with BlueCare Dental PPO, you'll get one of the highest maximum annual benefit levels available – up to $1,500 per person per year.

For information on eligibility requirements and to sign up for dental coverage that fits your needs, please call us toll-free at 866-514-8044.

Blue365®

Member discount program

Blue365 is just one more advantage of being a 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.

You can sign up for Blue365, our member discount program that offers deals from brands like Reebok, Jenny Craig® and Nutrisystem®. Log in to Blue Access for Members or visit ***www.Blue365Deals.com/BCBSIL/***.

Davis Vision℠ and TruVision
888-897-9350 or 877-882-2020

Save on eyeglasses as well as contact lenses, laser vision correction services, examinations and accessories. Find out more when you log in to BAM. 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 has 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.

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

Jenny Craig can help you reach your weight loss goals. You will get one-on-one support from a trained weight loss expert. Your consultant will give you a tailored program based on the basic 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. To get a special savings coupon, log in to BAM.

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.* Log in to BAM and access the Life Time Fitness website to find a free, seven-day pass to try out the location nearest you.

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 electronic toothbrush, mouth rinse, floss, and many more. To shop in the P&G estore, log in to BAM and click on Member Discounts under Quick Links.

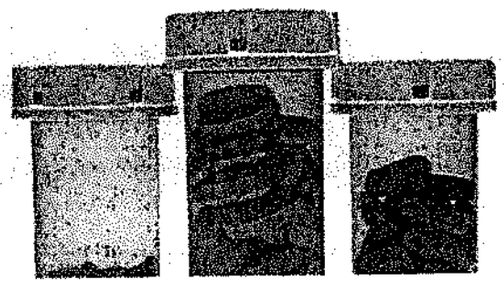
** Proof of Blue Cross and Blue Shield of Illinois coverage is needed. The $0 enrollment fee offer is only for new members who enroll online at www.Blue365Deals.com/BCBSIL/. A $35 administrative fee applies to all memberships. Monthly dues and taxes may also apply. Members' prices, dues and fees may 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.*

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

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.

Mail service for prescriptions

It's all about convenience



As a BCBSIL member, you have a mail-service prescription drug program available for your maintenance medications. This benefit saves you time and money. Members pay a copayment, coinsurance or a combination, depending on their plan. Just ask your doctor for a written prescription for up to 90 days for each medication you want delivered to your home. You can find more information on BAM under the **My Coverage** tab.

If you have any questions about cost or benefit coverage, call the Blue Cross and Blue Shield Pharmacy Line at 800-423-1973, Monday through Friday, 7 a.m. to 11 p.m., and Saturday and Sunday 7:30 a.m. to 8 p.m. CT. Have your Blue Cross and Blue Shield ID card handy when you call.

Travel with confidence

You're covered!

With our BlueCard® PPO Program, Blue Cross and Blue Shield (BCBS) Plans across the country work together to ensure you receive reliable, affordable health care whenever you're away from home. When you use BlueCard PPO network providers (even while traveling outside your local Plan service area), you will receive the network benefits available through your health plan.

So, when you need medical services outside your local Plan service area, call the customer service telephone number on the back of your ID card. Or call the BlueCard Access telephone number at 800-810-BLUE (2583). The "suitcase" logo on your ID card tells providers that you are part of the BlueCard PPO Program.

Learn more about taking care of your health

Facebook
facebook.com/
bluecrossblueshieldofillinois

Twitter
twitter.com/bcbsil

YouTube
youtube.com/bcbsil

RIDER TO THE POLICY TO IMPLEMENT
ILLINOIS WELLNESS COVERAGE

The Policy, to which this Rider is attached and becomes a part, is hereby amended as stated below:

The changes below are effective June 1, 2010.

GENERAL PROVISIONS

The following will be added to the GENERAL PROVISIONS SECTION of the Policy:

VALUE BASED DESIGN PROGRAMS

Blue Cross and Blue Shield has the right to offer a health behavior wellness, maintenance, or improvement program that allows for a reward, a contribution, a reduction in premiums or reduced medical, prescription drug or equipment Copayments, Coinsurance or Deductibles, or a combination of these incentives for participation in any such program offered or administered by Blue Cross and Blue Shield or an entity chosen by Blue Cross and Blue Shield to administer such program.

Except as amended by this Rider, all other terms, conditions, limitations and exclusions of the Policy, to which this Rider is attached, will remain in full force and effect.

Attest:

Health Care Service Corporation
a Mutual Legal Reserve Company
(Blue Cross and Blue Shield of Illinois)

Karen Atwood

Karen Atwood
President

RIDER TO THE POLICY

Effective Date: 10/01/2010

The Policy to which this Rider is attached and becomes a part, is amended as stated below.

EXCLUSIONS—WHAT IS NOT COVERED

The hearing aid exclusion is revised to read as follows:

— Hearing aids, except for bone anchored hearing aids (osseointegrated auditory implants), or examinations for the prescription or fitting of hearing aids, unless otherwise specified in this Policy.

Except as amended by this Rider, all terms, conditions, limitations and exclusions of the Policy to which this Rider is attached will remain in full force and effect.

Blue Cross and Blue Shield,
a Division of Health Care Service Corporation,
a Mutual Legal Reserve Company

Jeffrey R. Tikkanen
President, Retail Markets

RIDER TO THE POLICY

Effective Date: January 1, 2012

The Policy to which this Rider is attached and becomes a part, is amended as stated below.

GENERAL PROVISIONS

The **GENERAL PROVISIONS** section of your Policy is modified to add the following:

PREMIUM REBATES, PREMIUM ABATEMENTS AND COST-SHARING

a. **Rebate.** In the event federal or state law requires Blue Cross and Blue Shield to rebate a portion of annual premiums paid, Blue Cross and Blue Shield will directly provide any rebate owed participants or former participants to such persons in amounts as required by law.

b. **Abatement.** Blue Cross and Blue Shield may from time to time determine to abate (all or some of) the premium due under this Policy for particular period(s).

   Any abatement of premium by Blue Cross and Blue Shield represents a determination by Blue Cross and Blue Shield not to collect premium for the applicable period(s) and does not effect a reduction in the rates under this Policy. An abatement for one period shall not constitute a precedent or create an expectation or right as to any abatement in any future periods.

c. Blue Cross and Blue Shield makes no representation or warranty that any rebate or abatement owed or provided is exempt from any federal, state or local taxes (including any related notice, withholding or reporting requirements). It will be the obligation of each participant or former participant (if applicable) owed or provided a rebate or an abatement to determine the applicability of and comply with any applicable federal, state or local laws or regulations.

d. **Cost-Sharing.** Blue Cross and Blue Shield reserves the right from time to time to waive or reduce the Coinsurance, Copayments and/or Deductibles under this Policy.

The provisions of this Rider shall be in addition to (and do not take the place of) the other terms and conditions of this Policy.

This Rider shall become effective on the date stipulated above. Any conflict between the terms of this Rider and the Policy shall be resolved so that the terms of this Rider supersede the relevant terms of the Policy. In the event of any inconsistency or conflict between the terms of the Rider and the terms of the Policy, the terms of this Rider shall be deemed to control.

Except as amended by this Rider, all other terms, conditions, limitations and exclusions of the Policy to which this Rider is attached will remain in full force and effect.

Attest:

Health Care Service Corporation
a Mutual Legal Reserve Company
(Blue Cross and Blue Shield of Illinois)

Deborah Dorman-Rodriguez
Secretary

Patricia A. Hemingway Hall
President

DB-A86 HCSC

$250 or $500 Deductible

Outline of Coverage for Comprehensive Major Medical Plus

BlueCross BlueShield of Illinois

OB3784 Rev.10/03

INDIVIDUAL COMPREHENSIVE
MAJOR MEDICAL PLUS

$250 or $500 Deductible

Outline of Coverage

1. READ YOUR POLICY CAREFULLY—This outline of coverage provides a brief description of the important features of your Policy. This is not the insurance contract, and only the actual Policy provisions will control. The Policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR POLICY CAREFULLY!

2. Comprehensive Major Medical Plus Expense Coverage—This policy has features of a Comprehensive Major Medical Policy plus economic incentives for using designated providers of health care services. It provides, to persons insured, coverage for major Hospital, medical, and surgical expenses incurred as a result of a covered accident or sickness. Coverage is provided for daily Hospital room and board, miscellaneous Hospital services, surgical services, anesthesia services, In-Hospital medical services, and Out-of-Hospital care, subject to any Deductibles, Copayment provisions, or other limitations which may be set forth in the Policy. **Although you can go to the Hospital of your choice, your Hospital benefits under the Comprehensive Major Medical Plus plan will be greater when you use the services of a participating Hospital.**

BASIC PROVISIONS	PARTICIPATING PROVIDER COVERAGE
Lifetime Benefit	$5,000,000
Deductible Per individual, per calendar year. (If two or more family members receive covered services as a result of injuries received in the same accident, only one Deductible will apply.)	$250 or $500
Family Aggregate Deductible Equal to three times the individual Deductible per family, per calendar year.	3 x individual calendar year Deductible
Carryover Deductible If an insured incurs covered expenses for the Deductible in the last three months of the calendar year, we will carry over that amount as credit toward the Deductible for the next following calendar year.	
Inpatient/Outpatient Hospital Services (For mental health coverage levels, please refer to mental health benefits on the next page.)	100%
Inpatient/Outpatient Hospital Diagnostic Services Includes X-rays, lab tests, EKGs, ECGs, pathology services, pulmonary function studies, radioisotope tests, and electromyograms.	100%
Outpatient Emergency Care For both Hospital and Physician (Deductible does not apply).	100%
Additional Surgical Opinion Program Following a recommendation for elective surgery, provides additional consultations and related diagnostic service by a Physician, as needed (Deductible does not apply).	100%
Physician Charges	
Medical/Surgical Services (Inpatient and Outpatient)	80%
Office and/or Home Visits (including lab, diagnostic services, and allergy tests)	80%
Other Covered Services Of a registered physical, occupational, or speech therapist ($3,000/calendar year for each*); chiropractic services rendered by a Physician or chiropractor ($1,000/calendar year*); ambulance service; durable medical equipment; artificial limbs and other prosthetic devices; oxygen and its administration; blood plasma; private duty nursing services ($1,000/month*); Temporomandibular Joint Dysfunction (TMJ) and related disorders ($1,000 lifetime limit*); leg, arm, back, and neck braces; surgical dressing; casts and splints.	80%
Well-Child Care To age 16. Includes immunizations, physical exams ($500/calendar year/dependent).	80%

BASIC PROVISIONS	PARTICIPATING PROVIDER COVERAGE
Outpatient Prescription Drug Benefit After copayment, benefits are paid at 100% of remaining Eligible Charge for drugs purchased at a Participating Prescription Drug Provider and 75% if purchased at a Non-Participating Prescription Drug Provider.	$10 copay per prescription for generic drugs* $25 copay per prescription for brand name drugs*
Home Delivery: Maintenance drugs are available through home delivery. Up to a 90 day supply may be purchased through the Home Delivery Program. Benefits are paid at 100% of the remaining Eligible Charge after copayment for all home delivery drugs.	$10 copay per prescription for generic drugs* $25 copay per prescription for brand name drugs*
Mental Illness Treatment and Substance Abuse Rehabilitation Treatment Maximum lifetime benefit of $25,000. (Coverage levels apply to treatment received from either Participating or Non-Participating Providers.)	
Inpatient care limited to $10,000/calendar year*	
First 10 days	80%
Thereafter	50%
Outpatient care limited to $1,000/calendar year*	50%
Optional Maternity Coverage When elected, maternity benefits will begin 365 days after maternity coverage effective date.	
Inpatient/Outpatient Hospital services	100%
Medical and surgical services	80%
Out-of-Pocket Expense Limit The amount of money an individual pays toward covered expenses during any one calendar year, excluding the Deductibles. Applies to both Participating and Non-Participating Hospital charges. MSA copayment, charges in excess of Usual and Customary Fees or Eligible Charges, Deductibles, Coinsurance and Deductibles resulting from hospital services rendered by a Non-Plan Hospital or Non-Plan Provider, and items asterisked (*) do not apply to any out-of-pocket limit.	$1,000
Family Aggregate Out-of-Pocket Expense Limit Equal to three times the individual out-of-pocket limit, per family, per calendar year.	$3,000
Medical Services Advisory (MSA®) The MSA helps you maximize your benefits. Notification required prior to all elective Hospital admissions. Emergency and maternity admission notification required within two working days of admission. If individual does not notify MSA or follow advice given, Hospital benefits are reduced by $1,000.*	

Benefits for covered services are provided at either the Eligible Charge or the Usual and Customary Fee.

IF USING A NON-PARTICIPATING OR NON-PLAN HOSPITAL...

A $300 per admission Deductible will apply.* This Deductible doesn't apply to individual or family aggregate Deductible. Hospital benefits shown above, which are paid at 100% at Participating Hospitals, are paid at 80% at Non-Participating Hospitals, and 50% at Non-Plan Hospitals, except for Outpatient Hospital and Physician emergency care, and additional surgical opinions which are paid at 100%, regardless of the Hospital selected.**

** Does not apply to out-of-pocket expense limit.*

*** Inpatient mental illness benefits are paid at 80% for the first 10 days.*

Pre-Existing Conditions Limitation Pre-existing Conditions are those health conditions which were diagnosed or treated by a provider during the 12 months prior to the coverage effective date, or for which symptoms existed which would cause an ordinarily prudent person to seek diagnosis or treatment. Any Pre-existing Condition will be subject to a waiting period of 365 days.

Premiums We may change premium rates only if we do so on a class basis for all DB-41 HCSC policies. Premiums can be changed based on age, sex, and rating area.

Guaranteed Renewability Coverage under this Policy will be terminated for non-payment of premium. Blue Cross and Blue Shield can refuse to renew this Policy only for the following reasons:

A. If all Policies bearing form number DB-41 HCSC are not renewed, written notice will be provided at least 90 days before coverage is discontinued. Furthermore, you may convert to any other individual policy Blue Cross and Blue Shield offers to the individual market.

B. In the event of fraud or an intentional misrepresentation of material fact under the terms of the coverage, written notice will be given at least 30 days before coverage is discontinued.

Exclusions and Limitations:

Hospitalization, services, and supplies which are not Medically Necessary. Services or supplies that are not specifically mentioned in this Policy; services or supplies for which benefits are available under any Worker's Compensation Law or other similar laws whether or not you make a claim for such compensation or receive such benefits, except where not required by law; services or supplies that are furnished to you by the local, state, or federal government; illness or injury as a result of war or an act of war; those that do not meet accepted standards of medical or dental practice; Investigational Services and supplies; Custodial Care Service; routine physical examinations, unless specifically stated in this Policy; Inpatient stay when the stay is primarily related to behavioral, social maladjustment, lack of discipline, or other anti-social actions which are not specifically the result of Mental Illness; Cosmetic Surgery and related services and supplies, except for the correction of congenital deformities or for conditions resulting from accidental injuries, scars, tumors, or diseases; services or supplies for which you are not required to make payment or would have no legal obligation to pay if you did not have this or similar coverage; charges for failure to keep a scheduled visit or charges for completion of a Claim form; personal hygiene, comfort, or convenience items commonly used for other than medical purposes, such as air conditioners, humidifiers, physical fitness equipment, televisions, and telephones; special braces, splints, specialized equipment, appliances, ambulatory apparatus, battery controlled implants, except as specifically mentioned in this Policy; blood derivatives which are not classified as drugs in the official formularies; eyeglasses, contact lenses, or cataract lenses and the examination for prescribing or fitting of glasses or contact lenses or for determining the refractive state of the eye, except as specifically mentioned in this Policy; treatment of flat foot conditions and the prescription of supportive devices for such conditions and the treatment of subluxations of the foot or routine foot care; immunizations, unless otherwise stated in this Policy; Maintenance Occupational Therapy, Maintenance Physical Therapy, and Maintenance Speech Therapy; Speech Therapy when rendered for the treatment of psychosocial speech delay, behavioral problems (including impulsive behavior and impulsivity syndrome), attention disorder, conceptual handicap, or mental retardation; hearing aids or examinations for the prescription or fitting of hearing aids; services and supplies provided for human organ or tissue transplants other than cornea, kidney, bone marrow, heart valve, muscular-skeletal, parathyroid, heart, heart/lung, lung, liver, pancreas or pancreas/kidney human or organ tissue transplants, unless otherwise specified in this Policy; services and supplies provided for the diagnosis and/or treatment of infertility including, but not limited to, Hospital services, Medical Care, therapeutic injections, fertility and other drugs, Surgery, artificial insemination, and all forms of in-vitro fertilization; Maternity coverage including related services and supplies, unless selected as an option (Complications of Pregnancy are covered as any other illness).

Blue Cross and Blue Shield of Illinois
Home Delivery Order Form — PrimeMail™ Pharmacy

INSTRUCTIONS: Please PRINT in CAPITAL letters using **black ink** only. Fill in the applicable ovals completely (●).

For information about your home delivery benefits, to preregister or to download additional order forms or a physician fax form, visit the Blue Cross Web site at **www.bcbsil.com** or call customer service at **800.423.1973.**

Member and Dependent History Section information is required only on the first order unless there is a change in health status. Indicate all known allergies, conditions or other current medications for you, your spouse, or your dependents by filling in the corresponding oval that matches the description. Please detail * as necessary. Contact your physician if you are unsure about any of this information.

MEMBER AND DEPENDENT HISTORY SECTION

Member ID Number (on face of member ID card) Group Number

Member Last Name Sex: M F

Member First Name MI Birth Date (MM/DD/YYYY)

PCN (lower face of ID card) Member Phone Number

I L – –

Permanent Address

City State Zip Code

Email Address

ALLERGIES							CONDITIONS							
None Known	Aspirin	Codeine	Penicillin	Sulfa	Tetracycline	Other Allergy*	None Known	Diabetes	Epilepsy	Glaucoma	Heart Condition	Hypertension	Ulcer	Other Condition*

* Please detail "other allergy " or "other condition," including related medications. _____

Dependent Last Name Sex: M F

Dependent First Name MI Birth Date (MM/DD/YYYY)

Email Address

ALLERGIES							CONDITIONS							
None Known	Aspirin	Codeine	Penicillin	Sulfa	Tetracycline	Other*	None Known	Diabetes	Epilepsy	Glaucoma	Heart Cond.	Hypertension	Ulcer	Other*

* Please detail "other allergy " or "other condition." _____

Dependent Last Name Sex: M F

Dependent First Name MI Birth Date (MM/DD/YYYY)

* Please detail "other allergy " or "other condition." _____

ALLERGIES							CONDITIONS							
None Known	Aspirin	Codeine	Penicillin	Sulfa	Tetracycline	Other*	None Known	Diabetes	Epilepsy	Glaucoma	Heart Cond.	Hypertension	Ulcer	Other*

Dependent Last Name Sex: M F

Dependent First Name MI Birth Date (MM/DD/YYYY)

* Please detail "other allergy " or "other condition." _____

ALLERGIES							CONDITIONS							
None Known	Aspirin	Codeine	Penicillin	Sulfa	Tetracycline	Other*	None Known	Diabetes	Epilepsy	Glaucoma	Heart Cond.	Hypertension	Ulcer	Other*

- **Do you want the Generic?** ____ **Yes** (if available and your doctor permits) ____ **No**
- Some health plans require the patient to pay the difference between generic and brand name cost. State law allows pharmacist to substitute a less expensive generically equivalent drug for a brand drug unless you or your physician directs otherwise.

Blue Cross and Blue Shield of Illinois Home Delivery Order Form — PrimeMail™

PRESCRIPTION SECTION — Please PRINT in CAPITAL letters using **black ink** only.

For **NEW** prescriptions you may use either:

- **MAIL** — Mail the original physician-signed prescriptions with this completed form to: **Blue Cross and Blue Shield of Illinois c/o PrimeMail Pharmacy, P.O. Box 650041, Dallas, TX 75265-0041**
- **FAX** — Your physician must fax both pages of this completed form, along with your prescription(s), to **877.774.6360** provided you have either previously completed and submitted this form or registered at **www.bcbsil.com**

For **REFILL** prescriptions you may use:

- **PHONE** — Call our automated refill line at 877.357.7463.
- **WEB** — Visit **www.bcbsil.com**
- **MAIL** — Mail this form with the refill information completed to: **Blue Cross and Blue Shield of Illinois c/o PrimeMail Pharmacy, P.O. Box 650041, Dallas, TX 75265-0041**

Prescription	Member	Spouse	Dependent	Patient Name	Physician Name/Phone Number/Drug Name (for new prescriptions only)	Prescription Numbers (for refills only)
1						
2						
3						
4						
5						
6						

PrimeMail Pharmacy staff may contact your physician for clarification and safety purposes, which may result in your physician prescribing a different, clinically-appropriate product. PrimeMail Pharmacy will dispense FDA-approved generic equivalents when available and appropriate.

PAYMENT SECTION — Payment is due with each order and may be made by credit card, check or money order.

Do not send cash. Orders received without payment will delay processing. Credit card is the only payment option for faxed orders. If you have questions about your payment amount, call the Prescription Drug Inquiry Unit at **800.423.1973.**

☐ **Payment by check or money order** (Make payable to Prime Therapeutics LLC and write your member ID number on the memo line.)

Check Amount: _____ Check Number: _____

☐ **Payment by credit card** (Provide information below) ☐ MasterCard ☐ Visa ☐ American Express ☐ Discover

☐ **Use credit card on file, with the last four digits:**

☐ **Use alternate credit card number** Expiration Date (MM/YYYY)

Your credit card will be charged for drug costs, expedited shipping (if requested) and any outstanding balances due.

☐ **Use this card for all future orders**

Credit card holder's signature

SHIPMENT SECTION — Delivery date does not include prescription processing time. Please choose your shipping method.

☐ **Regular** — no charge ☐ **Second Business Day*** ☐ **Next Business Day*** ***Additional costs charged to you**

If you've chosen Second Business Day or Next Business Day shipping, we are unable to ship to P.O. boxes. Shipping address must be a physical location.

☐ **Ship to Permanent Address**

Alternate Shipping Address (If different than permanent address)

City State Zip Code Phone Number

– –

Above address is: ☐ **For this order only** ☐ **For this and all future orders**

All medications in this order will be sent to the address provided on this form. If a family member's medication needs to be delivered to a separate address, please submit a separate order form.

By returning this form to PrimeMail, you consent to the use and release of your health information and that of your covered dependents (if you are their guardian or authorized representative) to your 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 the federal privacy regulations under HIPAA (Health Insurance Portability and Accountability Act of 1996).

Blue Cross and Blue Shield of Illinois Home Delivery Order Form — PrimeMail™

PRESCRIPTION SECTION — Please PRINT in CAPITAL letters using **black ink** only.

For **NEW** prescriptions you may use either:

- **MAIL** — Mail the original physician-signed prescriptions with this completed form to: **Blue Cross and Blue Shield of Illinois c/o PrimeMail Pharmacy, P.O. Box 650041, Dallas, TX 75265-0041**
- **FAX** — Your physician must fax both pages of this completed form, along with your prescription(s), to **877.774.6360** provided you have either previously completed and submitted this form or registered at **www.bcbsil.com**

For **REFILL** prescriptions you may use:

- **PHONE** — Call our automated refill line at 877.357.7463.
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Prescription	Member	Spouse	Dependent	Patient Name	Physician Name/Phone Number/Drug Name (for new prescriptions only)	Prescription Numbers (for refills only)
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5						
6						

PrimeMail Pharmacy staff may contact your physician for clarification and safety purposes, which may result in your physician prescribing a different, clinically-appropriate product. PrimeMail Pharmacy will dispense FDA-approved generic equivalents when available and appropriate.

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Do not send cash. Orders received without payment will delay processing. Credit card is the only payment option for faxed orders.
If you have questions about your payment amount, call the Prescription Drug Inquiry Unit at **800.423.1973.**

○ **Payment by check or money order** (Make payable to Prime Therapeutics LLC and write your member ID number on the memo line.)
Check Amount: _____ Check Number: _____

○ **Payment by credit card** (Provide information below) MasterCard ○ Visa ○ American Express ○ Discover

○ **Use credit card on file, with the last four digits:**

○ **Use alternate credit card number** Expiration Date (MM/YYYY)

Your credit card will be charged for drug costs, expedited shipping (if requested) and any outstanding balances due.

○ **Use this card for all future orders**

Credit card holder's signature

SHIPMENT SECTION — Delivery date does not include prescription processing time. Please choose your shipping method.

○ **Regular** — no charge ○ **Second Business Day*** ○ **Next Business Day*** ***Additional costs charged to you**

If you've chosen Second Business Day or Next Business Day shipping, we are unable to ship to P.O. boxes. Shipping address must be a physical location.

○ **Ship to Permanent Address**

Alternate Shipping Address (If different than permanent address)

City State Zip Code Phone Number

– –

Above address is: ○ **For this order only** ○ **For this and all future orders**

All medications in this order will be sent to the address provided on this form. If a family member's medication needs to be delivered to a separate address, please submit a separate order form.

By returning this form to PrimeMail, you consent to the use and release of your health information and that of your covered dependents (if you are their guardian or authorized representative) to your 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 the federal privacy regulations under HIPAA (Health Insurance Portability and Accountability Act of 1996).

Blue Cross and Blue Shield of Illinois
Home Delivery Order Form — PrimeMail™ Pharmacy

INSTRUCTIONS: Please PRINT in CAPITAL letters using **black ink** only. Fill in the applicable ovals completely (●).

For information about your home delivery benefits, to preregister or to download additional order forms or a physician fax form, visit the Blue Cross Web site at **www.bcbsil.com** or call customer service at **800.423.1973.**

Member and Dependent History Section information is required only on the first order unless there is a change in health status. Indicate all known allergies, conditions or other current medications for you, your spouse, or your dependents by filling in the corresponding oval that matches the description. Please detail * as necessary. Contact your physician if you are unsure about any of this information.

MEMBER AND DEPENDENT HISTORY SECTION

Member ID Number (on face of member ID card) | Group Number

Member Last Name | Sex: M F

Member First Name | MI | Birth Date (MM/DD/YYYY)

PCN (lower face of ID card) | Member Phone Number

I L – –

Permanent Address

City | State | Zip Code

Email Address

ALLERGIES							CONDITIONS							
None Known	Aspirin	Codeine	Penicillin	Sulfa	Tetracycline	Other Allergy*	None Known	Diabetes	Epilepsy	Glaucoma	Heart Condition	Hypertension	Ulcer	Other Condition*

* Please detail "other allergy " or "other condition," including related medications. _____

Dependent Last Name | Sex: M F

Dependent First Name | MI | Birth Date (MM/DD/YYYY)

Email Address

ALLERGIES							CONDITIONS							
None Known	Aspirin	Codeine	Penicillin	Sulfa	Tetracycline	Other*	None Known	Diabetes	Epilepsy	Glaucoma	Heart Cond.	Hypertension	Ulcer	Other*

* Please detail "other allergy " or "other condition." _____

Dependent Last Name | Sex: M F

Dependent First Name | MI | Birth Date (MM/DD/YYYY)

* Please detail "other allergy " or "other condition." _____

ALLERGIES							CONDITIONS							
None Known	Aspirin	Codeine	Penicillin	Sulfa	Tetracycline	Other*	None Known	Diabetes	Epilepsy	Glaucoma	Heart Cond.	Hypertension	Ulcer	Other*

Dependent Last Name | Sex: M F

Dependent First Name | MI | Birth Date (MM/DD/YYYY)

* Please detail "other allergy " or "other condition." _____

ALLERGIES							CONDITIONS							
None Known	Aspirin	Codeine	Penicillin	Sulfa	Tetracycline	Other*	None Known	Diabetes	Epilepsy	Glaucoma	Heart Cond.	Hypertension	Ulcer	Other*

- **Do you want the Generic?** ____ **Yes** (if available and your doctor permits) ____ **No**
- Some health plans require the patient to pay the difference between generic and brand name cost. State law allows pharmacist to substitute a less expensive generically equivalent drug for a brand drug unless you or your physician directs otherwise.

RIDER TO THE POLICY REGARDING
DEFINITIONS, EXCLUSIONS AND GENERAL PROVISIONS

(Applicable to Policies DB-22 HCSC Rev. 6/99, DB-23 HCSC Rev. 6/99, DB-40 HCSC and DB-41 HCSC)

The Policy, to which this Rider is attached and becomes a part, is hereby amended as stated below.

1. DEFINITIONS SECTION

The definition for **EMERGENCY MEDICAL CARE** in the DEFINITIONS SECTION of your Policy is amended to read:

EMERGENCY MEDICAL CARE ..... means services provided for the initial Outpatient treatment, including related Diagnostic Services, of a medical condition displaying itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect that the absence of immediate medical attention could result in: (i) placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (ii) serious impairment to bodily functions; or (iii) serious dysfunction of any bodily organ or part.

Examples of symptoms that may indicate the presence of an emergency medical condition include, but are not limited to, difficulty breathing, severe chest pains, convulsions or persistent severe abdominal pains.

2. EXCLUSIONS- WHAT IS NOT COVERED

The following item is hereby deleted from the EXCLUSIONS-WHAT IS NOT COVERED section of your Policy:

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

3. GENERAL PROVISIONS

The GENERAL PROVISIONS section of your Policy is expanded to include the following provision:

SEVERABILITY

In case any one or more of the provisions contained in this Policy shall, for any reason, be held to be invalid, illegal or unenforceable in any respect, such invalidity, illegality or unenforceability shall not affect any other provisions of this Policy, but this Policy shall be construed as if such invalid, illegal or unenforceable provision had never been contained herein.

Except as amended by this Rider, all the other terms, conditions, limitations and exclusions of the Policy, to which this Rider is attached, will remain in full force and effect.

Attest:

Hugo Tagli Jr.

Secretary

Health Care Service Corporation,
a Mutual Legal Reserve Company
(Blue Cross and Blue Shield of Illinois)

Raymond D. McCarley

President

DB-A33 HCSC

RIDER TO THE POLICY REGARDING REIMBURSEMENT PROVISION

The Policy to which this Rider is attached and becomes a part, is amended as stated below.

The following **REIMBURSEMENT PROVISION** is added to your Policy hereby amending any previous Reimbursement Provision under the Policy in its entirety to read as follows:

If you or one of your covered dependents (if you have Family Coverage) incur expenses for sickness or injury that occurred due to the negligence of a third party and benefits are provided for Covered Services described in this Policy, you agree:

a. Blue Cross and Blue Shield has the right to reimbursement for all benefits Blue Cross and Blue Shield provided from any and all damages collected from the third party for those same expenses whether by action at law, settlement, or compromise, by you or your legal representative as a result of that sickness or injury, in the amount of the total Eligible Charge or Provider's Claim Charge for Covered Services for which Blue Cross and Blue Shield has provided benefits to you, reduced by any Average Discount Percentage ("ADP") applicable to your Claim or Claims.

b. Blue Cross and Blue Shield is assigned the right to recover from the third party, or his or her insurer, to the extent of the benefits Blue Cross and Blue Shield provided for that sickness or injury.

Blue Cross and Blue Shield shall have the right to first reimbursement out of all funds you, your covered dependents, or your legal representative, are or were able to obtain from the same expenses for which Blue Cross and Blue Shield has provided benefits as a result of that sickness or injury.

You are required to furnish any information or assistance or provide any documents that Blue Cross and Blue Shield may reasonably require in order to obtain our rights under this provision. This provision applies whether or not the third party admits liability.

Except as amended by this Rider, all terms, conditions, limitations and exclusions of the Policy to which this Rider is attached will remain in full force and effect.

Attest:

Hugo Tagli Jr.

Secretary

Health Care Service Corporation,
a Mutual Legal Reserve Company
(Blue Cross and Blue Shield of Illinois)

President

RIDER TO THE POLICY REGARDING EXCLUSIONS AND HOW TO FILE A CLAIM PROVISIONS

The Policy, to which this Rider is attached and becomes a part, is hereby amended as stated below.

1. EXCLUSIONS- WHAT IS NOT COVERED

Under the EXCLUSIONS-WHAT IS NOT COVERED section of your Policy, the exclusion regarding services or supplies for which benefits are available under any Workers' Compensation Law or other similar laws is amended to read:

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

2. HOW TO FILE A CLAIM

Under the HOW TO FILE A CLAIM section of your Policy, the "Time of Payment of Claims" provision is amended to read:

TIME OF PAYMENT OF CLAIMS

Blue Cross and Blue Shield will pay all Claims within 30 days of receipt of all information required to process a Claim. In the event that Blue Cross and Blue Shield does not process a Claim within this 30-day period, you or the valid assignee shall be entitled to interest at the rate of 9% per year, from the 30th day after the receipt of all Claim information until the date payment is actually made. However, interest payment will not be made if the amount is $1.00 or less. Blue Cross and Blue Shield will notify you or the valid assignee when all information required to pay a Claim within 30 days of the Claim's receipt has not been received. (For information regarding assigning benefits, see "Payment of Claims and Assignment of Benefits" provision in the GENERAL PROVISIONS section of this Policy.)

Except as amended by this Rider, all terms and conditions of the Policy to which this Rider is attached shall remain in full force and effect.

Attest:

Hugo Tagli Jr.

Secretary

Health Care Service Corporation,
a Mutual Legal Reserve Company
(Blue Cross and Blue Shield of Illinois)

Raymond R. McCarthy

President

DB-A39 HCSC

RIDER TO THE POLICY REGARDING COVERAGE AND PREMIUM INFORMATION

(Applicable to policies DB–22 HCSC, DB–23 HCSC, DB–32 HCSC, DB–34 HCSC, DB–40 HCSC, DB–41 HCSC, DB–42 HCSC, DB–43 HCSC & DB–44 HCSC)

The Policy, to which this Rider is attached and becomes a part, is hereby amended as stated below.

Under the COVERAGE AND PREMIUM INFORMATION section of your Policy, the YOUR APPLICATION FOR COVERAGE provision is replaced in its entirety with the following:

YOUR APPLICATION FOR COVERAGE
Any omission or misstatement of a material fact on your application will result in cancellation or rescission of your Policy, retroactive to the Coverage Date.

In the event of such cancellation, Blue Cross and Blue Shield will refund any premium paid during the period for which cancellation is effected. However, Blue Cross and Blue Shield will deduct from the premium refund any amounts made in Claim Payments during this period and you will be liable for any Claim Payment amounts greater than the total amount of premiums paid during the period for which cancellation is effected.

At any time when Blue Cross and Blue Shield is entitled to rescind coverage already in force, Blue Cross and Blue Shield may instead, at its sole option, make an offer to reform the policy already in force, retroactive to the Coverage Date. Should you decline to accept the reformed policy, coverage will be rescinded.

Except as amended by this Rider, all terms and conditions of the Policy to which this Rider is attached will remain in full force and effect.

Attest:

Hugo Tagli Jr.

Secretary

Health Care Service Corporation,
a Mutual Legal Reserve Company
(Blue Cross and Blue Shield of Illinois)

President

OMNIBUS RIDER TO THE POLICY

The Policy, to which this Rider is attached and becomes a part, is hereby amended as stated below.

The benefit changes below are effective January 1, 2004.

A. DEFINITIONS SECTION

The following term and definition is added to the Definitions Section:

RESPITE CARE SERVICE.....means those services provided at home or in a facility to temporarily relieve the family or other caregivers (non-professional personnel) that usually provide or are able to provide such services to you.

B. PHYSICIAN BENEFIT SECTION

The following benefit provision is added to the Covered Services listed under the Physician Benefit Section:

Outpatient Contraceptive Services

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

C. HOSPICE CARE PROGRAM

The Hospice Care Program benefit section is amended as follows:

1. The life expectancy requirement is changed from six months to one year.
2. Respite Care Service is added as a service covered under the Hospice Care Program.
3. Respite care is removed from the list of services that are not covered under the Hospice Care Program.

D. OUTPATIENT PRESCRIPTION DRUG PROGRAM BENEFIT SECTION

The Outpatient Prescription Drug Program Benefit Section is replaced in its entirety by the following:

OUTPATIENT PRESCRIPTION DRUG PROGRAM BENEFIT SECTION

When you are being treated for an illness or accident, your Physician may prescribe certain drugs or medicines as part of your treatment. Your coverage includes benefits for drugs and this section of your Policy explains which drugs are covered and the benefits that are available for them. Benefits will be provided only if such drugs are Medically Necessary.

COVERED SERVICES

The drugs for which benefits are available under this Benefit Section are:

- drugs that require, by federal law, a written prescription;
- self-injectable insulin and insulin syringes.

Benefits for these drugs will be provided when:

- you have been given a written prescription for them by your Physician, Dentist, Optometrist or Podiatrist and
- you purchase the drugs from a Pharmacy or from a Physician, Dentist, Optometrist or Podiatrist who regularly dispenses drugs.

Benefits will not be provided for:

- drugs used for cosmetic purposes (including, but not limited to, Retin-A/Tretinoin and Minoxidil/Rogaine);
- any devices or appliances; and
- any charges that you may incur for the drugs being administered to you.

In addition, benefits will not be provided for any refills if the prescription is more than one year old.

Benefit Payment for Prescription Drugs

The benefits you receive and the Copayment amount you pay for drugs will differ depending upon whether or not they are obtained from a Participating Prescription Drug Provider and whether you obtain brand name or generic drugs.

"Participating Prescription Drug Provider" means a Pharmacy that has a written agreement with a Blue Cross and Blue Shield Plan or the entity chosen by Blue Cross and Blue Shield to administer its prescription drug program to provide services to you at the time you receive the services.

"Eligible Charge" means (a) in the case of a Provider which has a written agreement with a Blue Cross and Blue Shield Plan or the entity chosen by Blue Cross and Blue Shield to administer its prescription drug program to provide Covered Services to you at the time you receive the Covered Services, such Provider's Claim Charge for Covered Services and (b) in the case of a Provider which does not have a written agreement with a Blue Cross and Blue Shield Plan or the entity chosen by Blue Cross and Blue Shield to provide services to you at the time you receive Covered Services, either of the following charges for Covered Services:

(i) the charge which the particular Prescription Drug Provider usually charges for Covered Services, or

(ii) the agreed upon cost between Participating Prescription Drug Providers and a Blue Cross and Blue Shield Plan or the entity chosen by Blue Cross and Blue Shield to administer its prescription drug program, whichever is lower.

When you obtain drugs from a Participating Prescription Drug Provider, you must pay a Copayment amount of:

- **$10.00 for each prescription** - for generic drugs.
- **$25.00 for each prescription** - for brand name drugs.

When you obtain drugs from a Participating Prescription Drug Provider, you must pay the Copayment amount described above for each prescription. Benefits will be provided for the remaining Eligible Charge. One prescription means up to a 34 consecutive day supply of a drug. Certain drugs may be limited to less than a 34 consecutive day supply. However, for certain maintenance type drugs larger quantities may be obtained through the Home Delivery Presciption Drug Program. For information on these drugs, contact your Participating Prescription Drug Provider or your local Blue Cross and Blue Shield office.

When you obtain drugs from a non-Participating Prescription Drug Provider (other than a Participating Prescription Drug Provider), 75% of the Eligible Charge will be paid minus the Copayment amount.

Home Delivery Prescription Drug Program

In addition to the benefits described in this Benefit Section, your coverage includes benefits for maintenance type drugs obtained through the Home Delivery Prescription Drug Program. The Home Delivery Prescription Drug Program provides up to a 90-day supply of maintenance prescription medications. Maintenance Maintenance medications are drugs used on a continual basis for treatment of chronic health conditions (such as high blood pressure, arthritis or diabetes). For information about this program, contact the Blue Cross and Blue Shield Prescription Drug Inquiry Unit.

When you obtain drugs through the Home Delivery Prescription Drug Program, you must pay a Copayment amount of:

- **$10.00 for each prescription** - for generic drugs.
- **$25.00 for each prescription** - for brand name drugs.

E. EXCLUSIONS

The following exclusion is added:

— Respite Care Service, except as specifically mentioned in the Hospice Care Program.

F. HOW TO FILE A CLAIM

The following provision is added to the How To File A Claim section of your Policy:

FILING PRESCRIPTION DRUG CARD PROGRAM CLAIMS

In certain situations, you will have to file your own Claims in order to obtain benefits under the Prescription Drug Card Program. This is primarily true when you did not receive an identification card, the pharmacy was unable to transmit a claim or you received benefits from a non-Participating Prescription Drug Provider. To do so, follow these instructions:

1. Complete a Prescription Drug Card Program Claim Form. These forms are available from your local Blue Cross and Blue Shield office.
2. Attach copies of all pharmacy receipts to be considered for benefits. These receipts must be itemized.
3. Mail the completed Claim Form with attachments to:

   Blue Cross and Blue Shield
   P. O. Box 853901
   Richardson, Texas 75085-3901

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

G. GENERAL PROVISIONS

The Blue Cross And Blue Shield's Separate Financial Arrangements With Providers section of the General Provisions of your Policy is expanded to include the following provision:

Blue Cross and Blue Shields' Separate Financial Arrangements with Prescription Drug Providers

Blue Cross and Blue Shield hereby informs you that it has contracts, either directly or indirectly, with Prescription Drug Providers ("Participating Prescription Drug Providers") to provide prescription drug services to all persons entitled to prescription drug benefits under health policies and contracts to which Blue Cross and Blue Shield is a party, including all persons covered under this Policy. Under its contracts with Participating Prescription Drug Providers, Blue Cross and Blue Shield may receive from these Providers discounts for prescription drugs dispensed to you. You are not entitled to receive any portion of any such payments, discounts and/or other allowances.

In addition, Blue Cross and Blue Shield has entered into agreements with certain entity(ies) to provide, on Blue Cross and Blue Shield's behalf, Claim Payments and certain administrative services for your prescription drug benefits. This entity(ies) is referred to as a pharmacy benefit manager. The pharmacy benefit manager has agreements with pharmaceutical manufacturers to receive rebates for using their products. The pharmacy benefit manager shares a portion of those rebates with Blue Cross and Blue Shield. You are not entitled to receive any portion of such rebates as they are figured into the pricing of the product.

Except as amended by this Rider, all other terms, conditions, limitations and exclusions of the Policy, to which this Rider is attached, will remain in full force and effect.

Attest:

Hugo Tagli Jr.

Secretary

Health Care Service Corporation,
a Mutual Legal Reserve Company
(Blue Cross and Blue Shield of Illinois)

President

OMNIBUS RIDER TO THE POLICY

The Policy, to which this Rider is attached and becomes a part, is amended as stated below.

A. DEFINITIONS SECTION

1. The following definition of **Coordinated Home Care Program** is added replacing any previous definition of the same name:

   COORDINATED HOME CARE PROGRAM.....means an organized skilled patient care program in which care is provided in the home. Care may be provided by a Hospital's licensed home health department or by other licensed home health agencies. You must be homebound (that is, unable to leave home without assistance and requiring supportive devices or special transportation) and you must require Skilled Nursing Service on an intermittent basis under the direction of your Physician. This program includes Skilled Nursing Service by a registered professional nurse, the services of physical, occupational and speech therapists, Hospital laboratories, and necessary medical supplies. The program does not include and is not intended to provide benefits for Private Duty Nursing Service. It also does not cover services for activities of daily living (personal hygiene, cleaning, cooking, etc.).

   A "Plan Coordinated Home Care Program" means a Coordinated Home Care Program which has a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and Blue Shield Plan or Blue Cross Plan to provide services to you at the time service is rendered to you.

   A "Non–Plan Coordinated Home Care Program" means a Coordinated Home Care Program which does not have an agreement with a Blue Cross and Blue Shield Plan or Blue Cross Plan but has been certified as a home health agency in accordance with the guidelines established by Medicare.

2. The definition of **Custodial Care Service** is deleted and replaced with the following:

   CUSTODIAL CARE SERVICE.....means any service primarily for personal comfort or convenience that provides general maintenance, preventive, and/or protective care without any clinical likelihood of improvement of your condition. Custodial Care Service also means those services which do not require the technical skills, professional training and clinical assessment ability of medical and/or nursing personnel in order to be safely and effectively performed. These services can be safely provided by trained or capable non–professional personnel, are to assist with routine medical needs (e.g. simple care and dressings, administration of routine medications, etc.) and are to assist with activities of daily living (e.g. bathing, eating, dressing, etc.). Custodial Care Service also means providing care on a continuous Inpatient or Outpatient basis without any clinical improvement by you.

3. The definition of **Eligible Charge** is deleted and replaced with the following:

   ELIGIBLE CHARGE.....means (a) in the case of a Provider which has a written agreement with Blue Cross and Blue Shield to provide care to you at the time Covered Services are rendered, such Provider's Claim Charge for Covered Services and (b) in the case of a Provider which does not have a written agreement with Blue Cross and Blue Shield to provide care to you at the time Covered Services are rendered, the amount for Covered Services determined by Blue Cross and Blue Shield based on the following order:

   (i) the charge which is within the range of charges other similar Hospitals or facilities in similar geographic areas charge their patients for the same or similar services, as reasonably determined by Blue Cross and Blue Shield, if available; or

   (ii) the amount that Centers for Medicare and Medicaid ("CMS") reimburses the Hospitals or facilities in similar geographic areas for the same or similar services rendered to members in the Medicare program; or

(iii) the charge which the particular Hospital or facility usually charges its patients for Covered Services.

4. The following definition of **Hospice Care Program Service** is added replacing any previous definition of the same name:

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

5. The definition of **Long Term Care Services** is added as follows:

   LONG TERM CARE SERVICES.....means those social services, personal care services and/or Custodial Care Services needed by you when you have lost some capacity for self-care because of a chronic illness, injury or condition.

6. The definition of **Maintenance Care** is added as follows:

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

7. The definition of **Private Duty Nursing Service** is deleted and replaced with the following:

   PRIVATE DUTY NURSING SERVICE.....means Skilled Nursing Service provided on a one-to-one basis by an actively practicing registered nurse (R.N.) or licensed practical nurse (L.P.N.). Private Duty Nursing is shift nursing of 8 hours or greater per day and does not include nursing care of less than 8 hours per day. Private Duty Nursing Service does not include Custodial Care Service.

8. The definition of **Skilled Nursing Facility** is deleted and replaced with the following:

   SKILLED NURSING FACILITY.....means an institution or a distinct part of an institution which is primarily engaged in providing comprehensive skilled services and rehabilitative Inpatient care and is duly licensed by the appropriate governmental authority to provide such services.

   A "Plan Skilled Nursing Facility" means a Skilled Nursing Facility which has a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and Blue Shield Plan or Blue Cross Plan to provide services to you at the time services are rendered to you.

   A "Non-Plan Skilled Nursing Facility" means a Skilled Nursing Facility which does not have an agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and Blue Shield Plan or Blue Cross Plan but has been certified in accordance with guidelines established by Medicare.

   An "Uncertified Skilled Nursing Facility" means a Skilled Nursing Facility which does not meet the definition of a Plan Skilled Nursing Facility and has not been certified in accordance with the guidelines established by Medicare.

9. The definition of **Skilled Nursing Service** is deleted and replaced with the following:

   SKILLED NURSING SERVICE.....means those services provided by a registered nurse (R.N.) or licensed practical nurse (L.P.N.) which require the clinical skill and professional training of an R.N. or L.P.N. and which cannot reasonably be taught to a person who does not have specialized skill and professional training. Benefits for Skilled Nursing Service will not be provided due to the lack of willing or available non-professional personnel. Skilled Nursing Service does not include Custodial Care Service.

10. The definition of **Substance Abuse Rehabilitation Treatment** is deleted and replaced with the following:

    SUBSTANCE ABUSE REHABILITATION TREATMENT.....means an organized, intensive, structured, rehabilitative treatment program of either a Hospital or Substance Abuse Treatment Facility. It does not include programs consisting primarily of counseling by individuals other than a Physician, Psychologist, Clinical Social Worker or Clinical Professional Counselor, court ordered

evaluations, programs which are primarily for diagnostic evaluations, mental retardation or learning disabilities, care in lieu of detention or correctional placement or family retreats.

B. ANESTHESIA SERVICES

The following **Anesthesia Services** provision is added to the Physician Benefit Section replacing any previous provision of the same name or under the name **Anesthesia**:

> Anesthesia Services—if administered at the same time as a covered surgical procedure in a Hospital or Ambulatory Surgical Facility or by a Physician other than the operating surgeon or by a CRNA. However, benefits will be provided for anesthesia services administered by oral and maxillofacial surgeons when such services are rendered in the surgeon's office or Ambulatory Surgical Facility.
>
> In addition, benefits will be provided for anesthesia administered in connection with dental care treatment rendered in a Hospital or Ambulatory Surgical Facility if (a) a child is age 6 and under, (b) you have a chronic disability, or (c) you have a medical condition requiring hospitalization or general anesthesia for dental care.

C. PRIVATE DUTY NURSING SERVICE

The **Private Duty Nursing Service** provision of the Other Covered Services section is deleted and replaced with the following:

> Private Duty Nursing Service—Benefits for Private Duty Nursing Service will be provided to you in your home only when the services are of such a nature that they cannot be provided by non-professional personnel and can only be provided by a licensed health care provider. No benefits will be provided when a nurse ordinarily resides in your home or is a member of your immediate family. Private Duty Nursing includes teaching and monitoring of complex care skills such as tracheotomy suctioning, medical equipment use and monitoring to home caregivers and is not intended to provide for long term supportive care. Benefits for Private Duty Nursing Service will not be provided due to the lack of willing or available non-professional personnel. Benefits for Private Duty Nursing Service will be limited to a maximum of $1,000 per month.

D. SKILLED NURSING FACILITY CARE

The **Skilled Nursing Facility Care** provision of the Special Conditions section is amended to include the following statement:

> No benefits will be provided for admissions to a Skilled Nursing Facility which are for the convenience of the patient or Physician or because care in the home is not available or the home is unsuitable for such care.

E. EXCLUSIONS–WHAT IS NOT COVERED

The **Exclusions – What Is Not Covered** section of your Policy is amended as follows:

1. The exclusion regarding services and supplies which do not meet accepted standards of medical and/or dental practice is deleted in its entirety and replaced with the following:
   - Services or supplies that do not meet accepted standards of medical and/or dental practice.
2. The following exclusion is added replacing any previous exclusion regarding Investigational Services and Supplies:
   - Investigational Services and Supplies and all related services and supplies, other than the cost of routine patient care associated with Investigational cancer treatment, if those services or supplies would otherwise be covered under the Policy if not provided in connection with an approved clinical trial program.
3. The following exclusions are added:
   - Long Term Care Service.
   - Inpatient Private Duty Nursing Service.
   - Maintenance Care.

— Wigs (also referred to as cranial prosthesis).

F. OUTPATIENT PRESCRIPTION DRUG PROGRAM BENEFIT SECTION

The Outpatient Prescription Drug Program Benefit Section is replaced in its entirety by the following:

OUTPATIENT PRESCRIPTION DRUG PROGRAM BENEFIT SECTION

When you are being treated for an illness or accident, your Physician may prescribe certain drugs or medicines as part of your treatment. Your coverage includes benefits for drugs which are self–administered and this section of your Policy explains which drugs are covered and the benefits that are available for them. Benefits will be provided only if such drugs are Medically Necessary.

COVERED SERVICES

The drugs for which benefits are available under this Benefit Section are:

- drugs which are self–administered that require, by federal law, a written prescription;
- self–injectable insulin and insulin syringes.

Benefits for these drugs will be provided when:

- you have been given a written prescription for them by your Physician, Dentist, Optometrist or Podiatrist;
- you purchase the drugs from a Pharmacy or from a Physician, Dentist, Optometrist or Podiatrist who regularly dispenses drugs and
- the drugs are self–administered.

Benefits will not be provided for:

- drugs used for cosmetic purposes (including, but not limited to, Retin-A/Tretinoin and Minoxidil/Rogaine);
- drugs for which there is an over–the–counter product available with the same active ingredient(s);
- drugs which are not self–administered;
- any devices or appliances; and
- any charges that you may incur for the drugs being administered to you.

In addition, benefits will not be provided for any refills if the prescription is more than one year old.

Benefit Payment for Prescription Drugs

The benefits you receive and the Copayment amount you pay for drugs will differ depending upon whether or not they are obtained from a Participating Prescription Drug Provider and whether you obtain brand name or generic drugs.

"Participating Prescription Drug Provider" means a Pharmacy that has a written agreement with a Blue Cross and Blue Shield Plan or the entity chosen by Blue Cross and Blue Shield to administer its prescription drug program to provide services to you at the time you receive the services.

"Eligible Charge" means (a) in the case of a Provider which has a written agreement with a Blue Cross and Blue Shield Plan or the entity chosen by Blue Cross and Blue Shield to administer its prescription drug program to provide Covered Services to you at the time you receive the Covered Services, such Provider's Claim Charge for Covered Services and (b) in the case of a Provider which does not have a written agreement with a Blue Cross and Blue Shield Plan or the entity chosen by Blue Cross and Blue Shield to provide services to you at the time you receive Covered Services, either of the following charges for Covered Services:

(i) the charge which the particular Prescription Drug Provider usually charges for Covered Services, or

(ii) the agreed upon cost between Participating Prescription Drug Providers and a Blue Cross and Blue Shield Plan or the entity chosen by Blue Cross and Blue Shield to administer its prescription drug program, whichever is lower.

When you obtain drugs from a Participating Prescription Drug Provider, you must pay a Copayment amount of:

- **$10.00 for each prescription** – for generic drugs.
- **$25.00 for each prescription** – for brand name drugs.

When you obtain drugs from a Participating Prescription Drug Provider, you must pay the Copayment amount described above for each prescription. Benefits will be provided for the remaining Eligible Charge. One prescription means up to a 34 consecutive day supply of a drug. Certain drugs may be limited to less than a 34 consecutive day supply. However, for certain maintenance type drugs larger quantities may be obtained through the Home Delivery Presciption Drug Program. For information on these drugs, contact your Participating Prescription Drug Provider or your local Blue Cross and Blue Shield office. Benefits for prescription inhalants will not be restricted on the number of days before an inhaler refill may be obtained.

When you obtain drugs from a non-Participating Prescription Drug Provider (other than a Participating Prescription Drug Provider), 75% of the Eligible Charge will be paid minus the Copayment amount.

Home Delivery Prescription Drug Program

In addition to the benefits described in this Benefit Section, your coverage includes benefits for maintenance type drugs obtained through the Home Delivery Prescription Drug Program. The Home Delivery Prescription Drug Program provides up to a 90–day supply of maintenance prescription medications. Maintenance medications are drugs used on a continual basis for treatment of chronic health conditions (such as high blood pressure, arthritis or diabetes). For information about this program, contact the Blue Cross and Blue Shield Prescription Drug Inquiry Unit.

When you obtain drugs through the Home Delivery Prescription Drug Program, you must pay a Copayment amount of:

- **$20.00 for each prescription** – for generic drugs.
- **$50.00 for each prescription** – for brand name drugs.

Except as amended by this Rider, all other terms, conditions, limitations and exclusions of the Policy, to which this Rider is attached, will remain in full force and effect.

Attest:

Hugo Tagli Jr.

Secretary

Health Care Service Corporation
a Mutual Legal Reserve Company
(Blue Cross and Blue Shield of Illinois)

President

RIDER TO THE CERTIFICATE OR POLICY REGARDING DEFINITIONS, HOSPITAL BENEFITS AND PHYSICIAN BENEFITS

The Certificate or Policy, to which this Rider is attached and becomes a part, is amended as stated below.

A. DEFINITIONS SECTION

1. The definition of **Creditable Coverage** is deleted and replaced with the following:

   Creditable Coverage .....means coverage you had under any of the following:

   (i) a group health plan;

   (ii) health insurance coverage for medical care under any hospital or medical service policy or HMO contract offered by a health insurance issuer;

   (iii) Medicare (Parts A, B or C of Title XVIII of the Social Security Act);

   (iv) Medicaid (Title XIX of the Social Security Act);

   (v) military service-related care;

   (vi) the Indian Health Service or of a tribal organization;

   (vii) a State health benefits risk pool;

   (viii) the Federal Employees Health Benefits Program;

   (ix) a public health plan maintained by a State, county or other political subdivision of a State;

   (x) Section 5(e) of the Peace Corps Act.

2. The definition for **Investigational or Investigational Services and Supplies** is replaced with the following:

   Investigational or Investigational Services and Supplies.....means procedures, drugs, devices, services and/or supplies which (1) are provided or performed in special settings for research purposes or under a controlled environment and which are being studied for safety, efficiency and effectiveness, and/or (2) are awaiting endorsement by the appropriate National Medical Specialty College or federal government agency for general use by the medical community at the time they are rendered to you, and (3) specifically with regard to drugs, combination of drugs and/or devices, are not finally approved by the Food and Drug Administration at the time used or administered to you.

3. The following term and definition is added:

   Physician Assistant.....means a duly licensed physician assistant performing under the direct supervision of a Physician, Dentist or Podiatrist and billing under such Provider.

B. HOSPITAL BENEFITS or HOSPITAL BENEFIT SECTION

The following is added to the Outpatient Covered Services provision:

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

If your Certificate or Policy includes benefits for Wellness Care, the following applies:

Benefits for colorectal cancer screening will be provided at the benefit payment described in the Wellness Care provision of this Certificate or Policy. Benefits for surgical procedures, such as colonoscopy and sigmoidoscopy, are not provided at the Wellness Care payment level. Such procedures will be provided at the benefit payment level for Surgery described in this Certificate or Policy.

C. MAJOR MEDICAL BENEFIT SECTION or PHYSICIAN BENEFIT SECTION

1. The following paragraph is added to the **Anesthesia Services** provision:

   In addition, benefits will be provided for anesthesia administered in connection with dental care treatment rendered in a Hospital or Ambulatory Surgical Facility if (a) a child is age 6 and under, (b) you have a chronic disability, or (c) you have a medical condition requiring hospitalization or general anesthesia for dental care.

2. The **Assistant Surgeon** provision is deleted and replaced with the following:

   Assist at Surgery- when performed by a Physician, Dentist or Podiatrist who assists the operating surgeon in performing covered Surgery in a Hospital or Ambulatory Surgical Facility. In addition, benefits will be provided for assist at Surgery when performed by a Physician Assistant or registered nurse practitioner under the direct supervision of a Physician, Dentist or Podiatrist.

3. The colorectal cancer screening Covered Service is deleted in its entirety and replaced with the following:

   Colorectal Cancer Screening-Benefits will be provided for colorectal cancer screening as prescribed by a Physician, in accordance with the published American Cancer Society guidelines on colorectal cancer screening or other existing colorectal cancer screening guidelines issued by nationally recognized professional medical societies or federal government agencies, including the National Cancer Institute, the Centers for Disease Control and Prevention, and the American College of Gastroenterology.

   If your Certificate or Policy includes benefits for Wellness Care, the following applies:

   Benefits for colorectal cancer screening will be provided at the benefit payment described in the Wellness Care provision of this Certificate or Policy. Benefits for surgical procedures, such as colonoscopy and sigmoidoscopy, are not provided at the Wellness Care payment level. Such procedures will be provided at the benefit payment level for Surgery described in this Certificate or Policy.

Except as amended by this Rider, all terms, conditions, limitations and exclusions of the Certificate or Policy to which this Rider is attached will remain in full force and effect.

Attest:

Hugo Tagliani Jr.
Secretary

Health Care Service Corporation
a Mutual Legal Reserve Company
(Blue Cross and Blue Shield of Illinois)

President

RIDER TO THE CERTIFICATE OR POLICY REGARDING MARRIAGE AND FAMILY THERAPISTS

The Certificate or Policy, to which this Rider is attached and becomes a part, is hereby amended as stated below.

1. **DEFINITIONS SECTION**

   The following term and definition is added:

   Marriage and Family Therapist ("LMFT").....means a duly licensed marriage and family therapist.

2. **MARRIAGE AND FAMILY THERAPIST**

   Your Certificate or Policy is amended to add Marriage and Family Therapist as an eligible provider for the treatment of Mental Illness and/or Substance Abuse Rehabilitation Treatment.

Except as amended by this Rider, all terms and conditions of the Certificate or Policy to which this Rider is attached will remain in full force and effect.

Attest:

Hugo Tagli Jr.
Secretary

Health Care Service Corporation
a Mutual Legal Reserve Company
(Blue Cross and Blue Shield of Illinois)

Raymond R. McCarthy
President

OMNIBUS RIDER TO THE POLICY

The Policy, to which this Rider is attached and becomes a part, is hereby amended as stated below.

A. HOSPITAL BENEFIT SECTION

The following provision is added to the list of Outpatient Covered Services:

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

B. PHYSICIAN BENEFIT SECTION

1. The following provision is added to the list of Covered Services:

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

2. The **Assistant Surgeon** provision is deleted and replaced with the following:

   Assist at Surgery—when performed by a Physician, Dentist or Podiatrist who assists the operating surgeon in performing covered Surgery in a Hospital or Ambulatory Surgical Facility. In addition, benefits will be provided for assist at Surgery when performed by a Registered Surgical Assistant or an Advanced Practice Nurse. Benefits will also be provided for assist at Surgery performed by a Physician Assistant under the direct supervision of a Physician, Dentist or Podiatrist.

3. If your Policy has a **Muscle Manipulations** provision, it is deleted and replaced with the following:

   Chiropractic and Osteopathic Manipulation

   Benefits will be provided for manipulation or adjustment of osseous or articular structures, commonly referred to as chiropractic and osteopathic manipulation, when performed by a person licensed to perform such procedures. Your benefits for chiropractic and osteopathic manipulation will be limited to the maximum stated in your Policy.

4. If your Policy has a **Physical Therapy** provision, the following sentence is added:

   Benefits will also be provided for preventive or Maintenance Physical Therapy when prescribed for persons affected by multiple sclerosis subject to the Outpatient Physical Therapy benefit maximum.

C. OTHER COVERED SERVICES

Amino acid-based formulas—Benefits will be provided for amino acid–based formulas for the diagnosis and treatment of eosinophilic disorders or short–bowel syndrome, when the prescribing Physician has issued a written order stating that the amino acid–based elemental formula is medically necessary.

D. EXCLUSIONS – WHAT IS NOT COVERED

If your Policy has an exclusion for **Maintenance Physical Therapy**, it is deleted and replaced with the following:

Maintenance Occupational Therapy, Maintenance Physical Therapy and Maintenance Speech Therapy, except as specifically mentioned in this Policy.

E. HOW TO FILE A CLAIM

The **Department of Insurance Address** provision is deleted and replaced with the following:

In compliance with Section 142(c) of the Illinois Insurance Code, you are hereby given notice of the addresses of the Consumer Divisions of the Illinois Department of Financial and Professional Regulations, Division of Insurance. The addresses are:

Illinois Department of Financial and
Professional Regulation, Division of Insurance
Consumer Division
100 West Randolph Street
Suite 15-100
Chicago, Illinois 60601

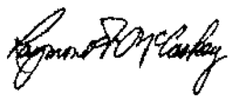
or

Illinois Department of Financial and
Professional Regulation, Division of Insurance
Consumer Services Section
320 West Washington Street
Springfield, Illinois 62767

Except as amended by this Rider, all other terms, conditions, limitations and exclusions of the Policy, to which this Rider is attached, will remain in full force and effect.

Attest:

Health Care Service Corporation
a Mutual Legal Reserve Company
(Blue Cross and Blue Shield of Illinois)



Raymond F. McCaskey
President

Thomas C. Lubben
Secretary

OMNIBUS RIDER TO THE POLICY

The Policy, to which this Rider is attached and becomes a part, is hereby amended as stated below.

A. GUARANTEED RENEWABILITY

Coverage under this Policy will be terminated for nonpayment of premiums. In addition, Blue Cross and Blue Shield may terminate or refuse to renew this Policy only for the following reasons:

1. If every Policy that bears this Policy form number* is not renewed. If this should occur:
   a. Blue Cross and Blue Shield will give you at least 90 days prior to written notice.
   b. You may convert to any other individual policy Blue Cross and Blue Shield offers to the individual market.
2. In the event of fraud or an intentional misrepresentation of material fact under the terms of this Policy. In this case, Blue Cross and Blue Shield will give you at least thirty (30) days prior written notice
3. If you no longer reside, live or work in an area for which Blue Cross and Blue Shield is authorized to do business.

Blue Cross and Blue Shield will never terminate or refuse to renew this Policy because of the condition of your health. Blue Cross and Blue Shield may uniformly modify coverage provided by every Policy which bears this Policy form number only on the coverage Renewal Date.

B. DEFINITIONS SECTION

The following will be added to the DEFINITIONS SECTION:

BENEFIT PERIOD.....means a period of one year which begins on January 1st of each year. When you first enroll under this coverage, your first Benefit Period begins on your Coverage Date, and ends on the first December 31st following that date.

RENEWAL DATE.....means January 1st of each year when your health coverage under this Policy renews for another Benefit Period.

Except as amended by this Rider, all other terms, conditions, limitations and exclusions of the Policy, to which this Rider is attached, will remain in full force and effect.

Attest:

Health Care Service Corporation
a Mutual Legal Reserve Company
(Blue Cross and Blue Shield of Illinois)

Raymond F. McCaskey
President

Thomas C. Lubben
Secretary

*DB–10 HCSC, DB-11 HCSC, DB-12 HCSC, DB-13 HCSC, DB-14 HCSC, DB-15 HCSC, DB-16 HCSC, DB-18 HCSC, DB-19 HCSC, DB-20 HCSC, DB-21 HCSC, DB-22 HCSC, DB-23 HCSC, DB-24 HCSC, DB-26 HCSC, DB-27 HCSC, DB-34 HCSC, DB-40 HCSC, DB-41 HCSC, DB-42 HCSC, DB-43 HCSC, DB-44 HCSC, DB-45 HCSC, DB-46 HCSC, DB-47 HCSC, DB-48 HCSC, DB-49 HCSC, DB-50 HCSC, DB-51 HCSC, DB-53 HCSC

OMNIBUS RIDER TO THE POLICY

The Policy, to which this Rider is attached and becomes a part, is hereby amended as stated below.

DEFINITIONS SECTION

The definition of **Eligible Charge** is deleted and replaced with the following:

ELIGIBLE CHARGE.....means (a) in the case of a Provider which has a written agreement with Blue Cross and Blue Shield to provide care to you at the time Covered Services are rendered, such Provider's Claim Charge for Covered Services and (b) in the case of a Provider which does not have a written agreement with Blue Cross and Blue Shield to provide care to you at the time Covered Services are rendered, the amount for Covered Services determined by Blue Cross and Blue Shield based on the following order:

(i) the amount that Centers for Medicare and Medicaid ("CMS") reimburses the Hospitals or facilities in similar geographic areas for the same or similar services rendered to members in the Medicare program; or

(ii) the charge which is within the range of charges other similar Hospitals or facilities in similar geographic areas charge their patients for the same or similar services; or

(iii) the charge which the particular Hospital or facility usually charges its patients for Covered Services.

Except as amended by this Rider, all other terms, conditions, limitations and exclusions of the Policy, to which this Rider is attached, will remain in full force and effect.

Attest:

Health Care Service Corporation
a Mutual Legal Reserve Company
(Blue Cross and Blue Shield of Illinois)

Deborah Dorman-Rodriguez

Deborah Dorman-Rodriguez
Secrectary

Patricia A. Hemingway Hall

Patricia A. Hemingway Hall
President and CEO

DB–A63 HCSC