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

DB-21 HCSC

CHILDREN'S MAJOR MEDICAL

BlueCross BlueShield
of Illinois

Your Health Care Benefits

DB-21 HCSC

notes

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. Please read your entire Policy very carefully. We hope that most of the questions you have about your coverage will be answered.

In this Policy we refer to our company as "Blue Cross and Blue Shield". The Definitions Section will explain the meaning of many of the terms used throughout the Policy. All defined terms will always begin with a capital letter.

THIS POLICY CONTAINS ALL THE PROVISIONS OF YOUR HEALTH CARE BENEFIT PROGRAM AND 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

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SOME THINGS YOU SHOULD KNOW

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 233 North Michigan Avenue, 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.

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 received any services or had a Claim paid under this Policy before the end of the 30-day period.

BENEFIT HIGHLIGHTS

Your health care benefits are highlighted below. However, to fully understand your benefits, it is very important that you read this entire Policy.

DEDUCTIBLE	
Deductible	$250 per benefit period**
OUT-OF-POCKET EXPENSE LIMIT	
— Participating Hospital	$1,000 per benefit period
— Non-Participating Hospital	$5,000 per benefit period
LIFETIME MAXIMUMS	
Separate Lifetime Maximum for Additional Transplants Coverage	$1,000,000**
Lifetime Maximum for all other benefits	$1,000,000**
Combined **Lifetime** Maximum Inpatient and Outpatient Mental Illness and Substance Abuse Treatment	$10,000**
Temporomandibular Joint Dysfunction and Related Disorders	$1,000**
DOLLAR MAXIMUMS	
Outpatient Speech Therapy	$3,000 per benefit period**
Outpatient Physical Therapy	$3,000 per benefit period**
Outpatient Occupational Therapy	$3,000 per benefit period**
Chiropractic Service	$1,000 per benefit period**
Wellness Care	$250 per benefit period
Private Duty Nursing Service	$1,000 per month**
Inpatient Substance Abuse Treatment and Inpatient Mental Illness Treatment Maximum	$1,000 per benefit period**
Outpatient Mental Illness Treatment and Outpatient Substance Abuse Treatment	$500 per benefit period**
SPECIAL PROGRAMS	
THE MEDICAL SERVICES ADVISORY PROGRAM	A special program designed to assist you in determining the course of treatment that will maximize your benefits under this Policy
MSA®	

REIMBURSEMENT PROVISION

If you 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 any payments received, whether by action at law, settlement or otherwise, to the extent that Blue Cross and Blue Shield has provided benefits to you; and

(b) that Blue Cross and Blue Shield will have a lien to the extent of benefits 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.

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

(4) 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 at its offices at 233 North Michigan Avenue, Chicago, Illinois 60601. 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.

(5) LIMITATIONS OF ACTIONS

No legal action may be brought to recover under this Policy, prior to the expiration of sixty (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 (3) 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.

(6) 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 since 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.

(7) TIME LIMIT ON CERTAIN DEFENSES

After 2 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 2 year period.

PAYMENT LEVELS

HOSPITAL BENEFITS

Participating Hospital:

— Inpatient Covered Services . . . . . 80% of the Eligible Charge

— Inpatient Mental Illness or Substance Abuse Admission . . . . 50% of the Eligible Charge

— Outpatient Covered Services . . . 80% of the Eligible Charge

Non-Participating Hospital:

— Inpatient Covered Services . . . . . 60% of the Eligible Charge

— Inpatient Mental Illness or Substance Abuse Admission . . . . 50% of the Eligible Charge

— Outpatient Covered Services . . . 60% of the Eligible Charge

Non-Plan Hospital: . . . . . 50% of the Eligible Charge

PHYSICIAN BENEFITS

Surgical/Medical Covered Services . . 80% of the U&C Fee*

OTHER COVERED SERVICES

Hospital and Physician Payment Level . . . . . 80% of the Eligible Charge or U&C Fee*

EMERGENCY CARE

Emergency Accident Care and Emergency Medical Care (Hospital and Physician) . . . . . 100% of the Eligible Charge or U&C Fee*

OUTPATIENT MENTAL SERVICE AND SUBSTANCE ABUSE TREATMENT

Hospital and Physician Payment Level . . . . . 50% of the Eligible Charge or U&C Fee*

*Usual and Customary Fee

**Does not apply to the Out-of-Pocket Expense Limit

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.

ADDITIONAL SURGICAL OPINION REFERRAL CENTER.....means the telephone referral center established by Blue Cross and Blue Shield to provide you with the names of Physicians with whom Blue Cross and Blue Shield has an agreement to provide additional surgical opinions.

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 to provide services to you at the time services are rendered to you.

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.

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 ("Participating Providers" and "Plan Providers") in Illinois to provide and pay for health care services to all persons entitled to health care benefits under individual policies and group policies and contracts to which Blue Cross and Blue Shield is a party, including all persons covered under this Policy, and that pursuant to its contracts with Participating and Plan Providers, under certain circumstances described therein, Blue Cross and Blue Shield may receive substantial payments from Participating and Plan Providers with respect to services rendered to all such persons for which Blue Cross and Blue Shield was obligated to pay the Participating or Plan Provider, or Blue Cross and Blue Shield may pay Participating and Plan Providers less than their Claim Charges for services, by discount or otherwise, or may receive from Participating and Plan Providers other allowances under Blue Cross and Blue Shield's contracts with them. You are not entitled to receive any portion of any such payments, discounts and/or other allowances. Further, all required deductible and copayment amounts under this Policy shall be calculated on the basis of the Eligible Charge for Covered Services rendered to you, irrespective of any separate financial arrangement between any Participating or Plan Provider and Blue Cross and Blue Shield.

(2) PAYMENT OF CLAIMS AND ASSIGNMENT OF BENEFITS

(a) All benefit payments may be made by Blue Cross and Blue Shield directly to any Provider furnishing the Covered Services for which such payment is due, and Blue Cross and Blue Shield is authorized by you to make such payments directly to such Providers. However, Blue Cross and Blue Shield reserves the right to pay any benefits that are payable under the terms of this Policy directly to you.

(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) Neither this Policy nor a Covered Person's claim for payment of benefits under this Policy are assignable in whole or in part to any person or entity at any time. 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.

(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

viewed. 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
Health Care Service Corporation
P.O. Box 2401
Chicago, Illinois 60690

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.

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.")

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

COORDINATED HOME CARE PROGRAM.....means an organized skilled patient care program initiated by a Hospital to facilitate early discharge of patient with a program of home care. Such home care may be rendered by the Hospital's duly licensed home health department or by other duly licensed home health agencies with which the Hospital has referral arrangements. 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 initiated by a Plan Hospital and which has a written agreement with Blue Cross and Blue Shield 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 Blue Cross and Blue Shield but has been certified as a home health agency in accordance with the guidelines established by Medicare.

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

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

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.

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 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 Blue Cross and Blue Shield but has been certified in accordance with the guidelines established by Medicare.

ELIGIBLE CHARGE.....means

(a) 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.

(b) 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:

(i) the charge which the particular Hospital or facility usually charges its patients for Covered Services, 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, 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 the initial Outpatient treatment, including related Diagnostic Service, of the sudden and unexpected onset of a medical condition which has such severe symptoms that the absence of immediate medical attention could result in serious and permanent medical consequences. Examples of these types of symptoms are severe chest pains, convulsions or persistent severe abdominal pains.

HOW TO FILE A CLAIM

In order to obtain your benefits under this Policy, a Claim must 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 that 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:

   Comprehensive Major Medical Department
   Blue Cross and Blue Shield
   233 North Michigan Avenue
   Chicago, Illinois 60601

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.

CLAIM REVIEW PROCEDURES

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 resulting interest amount is $1.00 or less.

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 re-

— 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 cornea, kidney, bone marrow, heart valve, muscular-skeletal or parathyroid human organ or tissue transplants, unless otherwise specified 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.

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.

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 located in Illinois which has a written agreement with Blue Cross and Blue Shield to provide services to you at the time services are rendered to you. A Plan Hospital also means a Hospital located in another state if the Hospital has a written agreement with the Blue Cross Plan of that state.

A "Participating Hospital" means a Plan Hospital that has a written agreement with Blue Cross and Blue Shield to provide Hospital services to participants in the Participating Provider Option program at the time services are rendered.

INDIVIDUAL COVERAGE.....means coverage under this Policy for you but not a 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 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 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, alive or dead, who weighs 5 pounds or more and who has no signs of post-maturity. Precautionary Medical Care due to adverse maternal age, poor prior obstetrical history, Pre-Existing Conditions, suspected genetic abnormality, all of which make complications more likely, will be considered as part of normal pregnancy.

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 participating 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.

NON-PARTICIPATING PROVIDER.....see definition of PROVIDER.

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 PSYCHIATRIC TREATMENT PROGRAM.....means a Blue Cross and Blue Shield approved planned therapeutic treatment program of a Hospital in which patients with Mental Illness spend days.

PARTICIPATING PROVIDER.....see definition of PROVIDER.

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

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 a 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.

— 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 or atomically 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.

— Treatment of temporomandibular joint syndrome with intra-oral prosthetic devices, or any other method which alters vertical dimension or treatment of temporomandibular joint dysfunction not caused by documented organic joint disease or physical trauma.

— 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, unless otherwise stated in this Policy.

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 this 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
Health Care Service Corporation
P.O. Box 2401
Chicago, Illinois 60690

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 which benefits are available under any Worker's Compensation Law or other similar laws.

— 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 is received, except 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.

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

PLAN PROVIDER.....see definitions of HOSPITAL, SKILLED NURSING FACILITY and SUBSTANCE ABUSE TREATMENT FACILITY.

PODIATRIST.....means a duly licensed podiatrist.

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

PRE-EXISTING 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) duly licensed to render Covered Services to you.

PARTICIPATING PROVIDER.....means a Plan Hospital, Plan facility or other Plan Provider which has been designated by Blue Cross and Blue Shield as a Participating Provider in the Plan's Participating Provider Option ("PPO") Program.

NON-PARTICIPATING PROVIDER.....means a Plan Hospital, Plan facility or other Plan Provider which has **not** been designated by Blue Cross and Blue Shield as a Participating Provider in the Plan's Participating Provider Option ("PPO") Program.

NON-PLAN PROVIDER.....means a Hospital or facility which does not have a written agreement with Blue Cross and Blue Shield or does not meet the definition of Participating Provider or Non-Participating 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:

COVERAGE AND PREMIUM INFORMATION

YOUR APPLICATION FOR COVERAGE

Your application for coverage under this Policy is subject to Evidence of Insurability. Any omission or misstatement of a material fact on your application will result in the cancellation of your coverage retroactive to your 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 the date that your coverage under this program begins (that is, your Coverage Date) and your Blue Cross and Blue Shield identification number. This information will be very important to you in obtaining your benefits.

ELIGIBILITY AND LIMITING AGE

Only your health care expenses are covered under this Policy, not the health care expenses of any other members of your family. Coverage under this Policy is available from age one until the age(s) stated below.

You must be unmarried and an Illinois resident to have coverage under this Policy. Also, if you are of school age, you must be a full-time student. Your coverage will automatically end on your 20th birthday. However, if you are continuing your education on a full-time student basis, your coverage will not end until your 25th birthday.

PAYMENT OF PREMIUMS

1. Your first premium is due on your Coverage Date. Later premiums are due and payable on the premium due date, which is the date that will appear on your billing statement.
2. The initial premium for Individual Coverage is based on your age at the time your coverage begins.
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:
   (i) 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,
   (ii) 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, and
   (iii) whenever you attain an age which results in a change in the premium amount due for your age category
4. If you fail to pay premiums to Blue Cross and Blue Shield within 31 days of

For Participating Hospitals

If, during one benefit period, your out-of-pocket expenses (the amount remaining unpaid after benefits have been provided) equal $1,000, any additional eligible Claims (except for Covered Services which have a separate dollar maximum specifically mentioned in this Policy and Hospital Covered Services rendered by a Non-Participating Hospital or Non-Plan facility) during that benefit period will be paid in full up to the Eligible Charge or Usual and Customary Fee.

This $1,000 may be reached by any combination of:

- the payments for which you are responsible after benefits have been provided (except for any expenses incurred for Covered Services rendered by a Non-Participating Hospital or a Non-Plan facility)
- and any unreimbursed expenses incurred for Covered Services within your prior contract's benefit period, if not completed.
- any Non-Participating or Non-Plan Hospital expenses for that portion of an Inpatient Hospital stay during which your condition was life threatening, as reasonably determined by Blue Cross and Blue Shield.

It does not include:

- your deductible
- charges that exceed the Eligible Charge or Usual and Customary Fee
- the co-payment resulting from Covered Services rendered by a Non-Participating Hospital, Non-Plan Hospital or Non-Plan facility
- charges for Covered Services which have a separate dollar maximum specifically mentioned in this Policy (except for Wellness Care Covered Services)
- co-payments resulting from noncompliance with the provisions of the Medical Services Advisory Program

For Non-Participating Hospitals

If, during one benefit period, your out-of-pocket expenses (the amount remaining unpaid after benefits have been provided) equal $5,000, any additional eligible Claims for Covered Services rendered by a Non-Participating Hospital or a Non-Plan facility (except for Covered Services which have a separate dollar maximum specifically mentioned in this Policy) during that benefit period will be paid in full up to the Eligible Charge.

This $5,000 may be reached by:

- the payments for Covered Services rendered by a Non-Participating Hospital or a Non-Participating facility for which you are responsible after the benefits have been provided

It does not include:

- your deductible
- the separate Inpatient Hospital admission deductible
- charges that exceed the Eligible Charge or Usual and Customary Fee
- the co-payment resulting from Covered Services you may receive from a Par-

Your benefits for Outpatient Mental Illness and Outpatient Substance Abuse are limited to a combined maximum of $500 per benefit period.

After your deductible, benefits for the Inpatient treatment of Mental Illness and Inpatient Substance Abuse Treatment (in a Blue Cross and Blue Shield approved program of a Participating Hospital or facility) will be provided at 50% of the Eligible Charge.

When you receive Covered Services for the Inpatient treatment of Mental Illness or Substance Abuse from a Physician or other professional Provider, benefits will be provided at 50% of the Usual and Customary Fee after you have met your deductible.

Your benefits for Inpatient treatment of Mental Illness and Inpatient Substance Abuse Treatment are limited to a maximum of $1,000 per benefit period.

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

A combined lifetime maximum of $10,000 will apply to benefits for Inpatient and Outpatient treatment of Mental Illness and/or Substance Abuse.

COMPLICATIONS OF PREGNANCY — Benefits will be paid for Covered Services received in connection with Complications of Pregnancy.

TEMPOROMANDIBULAR JOINT DYSFUNCTION AND RELATED DISORDERS (TMJ Benefits)

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.

PAYMENT PROVISIONS

Lifetime Maximum

The total maximum amount of benefits to which you are entitled under this Comprehensive Major Medical Program is $1,000,000.

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 that benefit period, 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

There are separate Out-of-Pocket Expense Limits applicable to Covered Services in Participating Hospitals and Non-Participating Hospitals.

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.

TERMINATION OF COVERAGE

This Policy will continue from your Coverage Date and from year to year thereafter, but will automatically terminate when you reach the limiting age. This Policy may also be cancelled at any time by either you or Blue Cross and Blue Shield by giving 30 days prior written notice. Further, this Policy may be cancelled for nonpayment of the appropriate premium when due or for your failure to perform any obligation or act required by this Policy.

REINSTATEMENT

If any premium is not paid within the time granted you for payment, a later acceptance of the 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, 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 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.

CONVERSION PRIVILEGE

Your coverage under this Policy will automatically terminate when you reach the limiting age or if you become eligible for Medicare due to a disability. At that time, you will be entitled to convert to a new Policy containing provisions which are generally offered to persons in your age or eligibility classification as long as you pay Blue Cross and Blue Shield the established charges for the new coverage within 30 days of the termination date of this Policy.

BENEFIT INFORMATION

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

YOUR BENEFIT PERIOD

Your benefit period is 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.

YOUR DEDUCTIBLE

Each benefit period you must satisfy a $250 deductible. In other words, after you have claims for more than $250 of Covered Services in a benefit period, your benefits will begin. In addition to this deductible, you must satisfy a separate $300 Non-Participating Hospital deductible if you are admitted to a Non-Participating Hospital.

If you have any expenses during the last three months of a benefit period which were, or could have been, applied to that benefit period's deductible, these expenses will also count as credit toward the deductible of the next benefit period.

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

EMERGENCY ACCIDENT CARE

EMERGENCY MEDICAL CARE

ADDITIONAL SURGICAL OPINION CONSULTATIONS

WELLNESS CARE

PRE-EXISTING CONDITIONS WAITING PERIOD

A Pre-Existing Conditions waiting period will not apply to this Policy as long as any Pre-Existing Condition you may have has been identified on your application for coverage.

Any Pre-Existing Condition which has not been identified on your application for coverage will be subject to a Pre-Existing conditions waiting period of 365 days. This Pre-Existing conditions waiting period will begin on your Coverage Date and will continue for 365 days. Until the Pre-Existing Conditions waiting period has ended, no benefits will be provided for a Pre-Existing Condition.

SUBSTANCE ABUSE TREATMENT

Benefits for all of the Covered Services previously described in this Policy are available for the treatment of Substance Abuse. In addition, benefits will be provided if these Covered Services are rendered by a Substance Abuse Treatment Facility.

For benefits to be provided at the Participating Hospital payment level, Covered Services must be provided by a Blue Cross and Blue Shield approved Substance Abuse Treatment program of a Participating Hospital or Plan Substance Abuse Treatment Facility. When you receive Covered Services in an approved program of a Non-Participating Hospital, benefits will be provided at the same level as payment for Covered Services in a Non-Participating Hospital. Benefits will not be provided for Substance Abuse 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 Treatment benefits for the treatment of alcoholism in a non-approved program or Non-Plan facility are determined differently. Benefits for the Inpatient treatment of alcoholism in a non-approved program or Non-Plan facility will be provided at 50% of the Eligible Charge. Your benefits for the Outpatient treatment of alcoholism will be as described below.

MENTAL ILLNESS SERVICES

Benefits for all of the Inpatient Covered Services previously described in this Policy are available for the treatment of Mental Illness. Medical Care for the treatment of a Mental Illness is eligible when rendered by a Physician or Psychologist and consists only of psychotherapy, group therapy, psychological testing and/or family counseling (interviews with the patient's family to obtain information that will help in treating the patient).

Benefits for the Outpatient treatment of Mental Illness are available only for individual or group psychotherapeutic treatments when rendered by a Physician or Psychologist. If these treatments are rendered in the Outpatient department of a Hospital, benefits will also be available for those charges.

Benefit Payment for Mental Illness and Substance Abuse Treatment

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

After you have met your deductible, benefits for Outpatient Substance Abuse Treatment (in a program approved by Blue Cross and Blue Shield) 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 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 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 or at 50% of the Usual and Customary Fee.

Exclusions

In addition to the other exclusions of this Policy, benefits will not be provided under the Additional Transplants Coverage Program for the following:

1. Services unrelated to a heart, heart/lung, liver, pancreas or pancreas/kidney transplant or unrelated to the diagnosis or treatment of an illness resulting directly from such transplant.
2. Cardiac rehabilitation services when not provided to the transplant recipient immediately after discharge from a Hospital for Additional Transplant Surgery.
3. Transportation by air ambulance for the donor or the recipient.
4. Travel time and related expenses required by a Provider.
5. Drugs which are Investigational.

Benefit Payment and Lifetime Maximum for Additional Human Organ Transplants

Your benefits for Additional Human Organ Transplants are the same as your benefits for any other condition. However, benefits for Additional Human Organ Transplants are subject to a lifetime maximum of $1,000,000. This lifetime maximum is separate from your lifetime maximum for all other benefits.

SKILLED NURSING FACILITY CARE

If you have been hospitalized, you may continue your recovery as an Inpatient in a Skilled Nursing Facility. However, you must be admitted to a Skilled Nursing Facility within 30 days after discharge from the Hospital or Coordinated Home Care Program.

Covered Services in a Skilled Nursing Facility

1. Bed, board and general nursing care.
2. Ancillary services (such as drugs and surgical dressings or supplies).

Your admission to a Skilled Nursing Facility is considered a continuation of your Inpatient Hospital stay.

After your have met your deductible, benefits for Covered Services rendered in a Plan Skilled Nursing Facility will be provided at 80% of the Eligible Charge.

Benefits for Covered Services rendered in a Non-Plan Skilled Nursing Facility will be provided at 50% of the Eligible Charge, once you meet your deductible.

AMBULATORY SURGICAL FACILITY

Benefits for all of the Covered Services previously described in this Policy are available for Outpatient Surgery. In addition, benefits will be provided if these services are rendered by an Ambulatory Surgical Facility. After you have met your deductible, benefits for services rendered by a Plan Ambulatory Surgical Facility will be provided at 80% of the Eligible Charge. Benefits for services in a Non-Plan Ambulatory Surgical Facility will be provided at 50% of the Eligible Charge.

MEDICAL SERVICES ADVISORY PROGRAM

Blue Cross and Blue Shield has established the office of the Medical Services Advisor to perform pre-admission review and length of stay review for your Inpatient Hospital services. The office of the Medical Services Advisor is staffed by trained, registered nurses and consulting Physicians under the supervision of Blue Cross and Blue Shield's Medical Director, a licensed Physician.

Failure to contact the Medical Services Advisor or to comply with the recommendations of the Medical Services Advisor may result in less benefits for you. Please read the provisions below very carefully.

PRE-ADMISSION REVIEW

Whenever a non-emergency Inpatient Hospital admission is recommended by your Physician, you must, in order to receive maximum benefits under this Policy, contact the Medical Services Advisor. You will receive a special MSA card that will give you the toll-free telephone number of the Medical Services Advisor at the time of your enrollment in this Medical Services Advisory Program. You should contact the Medical Services Advisor immediately upon being notified by your Physician of a scheduled Inpatient Hospital admission.

When you contact the Medical Services Advisor you should be prepared to provide the following information:

1. the name of your admitting Physician
2. the name of the Hospital where your admission has been scheduled
3. the scheduled admission date
4. a preliminary diagnosis or reason for the admission

The Medical Services Advisor will discuss the benefits available to you and will review the medical information provided. You or your admitting Physician may also receive a recommendation from the Medical Services Advisor to have your services performed on an Outpatient basis or to obtain an additional surgical opinion, if Surgery has been recommended by your Physician.

If an additional surgical opinion is recommended, the Medical Services Advisor will furnish you with the names of 3 Physicians with whom Blue Cross and Blue Shield has an agreement to render surgical opinions. You may obtain your additional surgical opinion from one of these Physicians or any Physician with whom Blue Cross and Blue Shield has an agreement to render surgical opinions. Benefits for the consultation will be provided at 100% of the Usual and Customary Fee without application of any deductible(s) which might otherwise be applicable under this Policy.

In addition to the additional surgical opinion consultations, benefits will also include related Diagnostic Service required by the consulting Physician. If you so request, benefits will be provided for another consultation when the need for Surgery, in your opinion, is not resolved by the first arranged consultation.

The Medical Services Advisor will provide you with the forms needed to advise Blue Cross and Blue Shield of the results of the additional surgical opinion(s). Regardless of the results of the additional surgical opinion, if you elect to have Sur-

gery you may do so without a reduction of the benefits provided under this Policy. However, Blue Cross and Blue Shield shall not in any event be liable for any act or omission of any Physician or any agent or employee of the Physician, including, but not limited to, a failure or refusal to render services to you or for providing or not providing you with the name of a particular Physician for your consultation.

LENGTH OF STAY REVIEW

Upon completion of the pre-admission review, the Medical Services Advisor will assign a length of stay to the proposed admission and will notify you, your admitting Physician and the Hospital in writing. The Hospital will contact the Medical Services Advisor in the event your admitting Physician recommends an extension of the assigned length of stay. In such a case, a Physician in the Medical Services Advisor's office will review the assigned length of stay with your admitting Physician to examine the possibility of an alternative to continued hospitalization and will determine whether or not continued hospitalization is Medically Necessary. Upon completion of this review, the Physician in the Medical Services Advisor's office will decide to either extend the assigned length of stay or to terminate benefits at the expiration of the assigned length of stay due to a finding that continued Inpatient hospitalization is not Medically Necessary.

If an extension of the assigned length of stay is approved by the Medical Services Advisor, you and your admitting Physician and the Hospital will be notified in writing of such decision and the Medical Services Advisor will periodically consult the Hospital and your admitting Physician in order to monitor the extended length of stay.

Should the Physician in the Medical Services Advisor's office deny an extension of the length of stay as not Medically Necessary, written notification of the decision will be provided to you, your admitting Physician and the Hospital. The decision of the Medical Services Advisor Physician will include written notice to the Hospital and your admitting Physician of the date upon which benefits will terminate.

In the event you remain hospitalized beyond the length of stay period assigned by the Medical Services Advisor, you will be responsible for all Hospital charges incurred after the expiration of the assigned length of stay.

Remember that your Blue Cross and Blue Shield Policy does not pay for the cost of hospitalization or any other health care services and supplies that are not Medically Necessary. As applied to the length of stay review, Medically Necessary means that Inpatient care and treatment will not be covered when, in the reasonable judgment of the Medical Services Advisor, your symptoms and condition no longer necessitate your continued stay in a Hospital. The fact that your Physician or another health care Provider may prescribe, order, recommend or approve continued Inpatient hospitalization beyond the length of stay authorized by the Medical Services Advisor does not of itself make such an Inpatient Hospital stay Medically Necessary.

Even if your Physician prescribes, orders, recommends, approves or views continued Inpatient hospitalization beyond the length of stay assigned by the Medical Services Advisor as Medically Necessary, Blue Cross and Blue Shield will not pay for Inpatient hospitalization which exceeds the assigned length of stay if the Medical Services Advisor decides an extension of the assigned length of stay is not Medically Necessary.

SPECIAL CONDITIONS AND PAYMENTS

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

HUMAN ORGAN TRANSPLANTS

Benefits for all of the Covered Services previously described in this Policy are available for human organ transplants. Benefits will be provided only for cornea, kidney, bone marrow, heart valve, muscular-skeletal or parathyroid 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.

ADDITIONAL HUMAN ORGAN TRANSPLANTS

In addition to those benefits mentioned above, your coverage also provides you with benefits for certain "Additional" Human Organ Transplants. This section will explain to you the benefits available under the Additional Human Organ Transplants Coverage Program.

Covered Services

Your Additional Human Organ Transplant benefits will cover services for a heart, heart/lung, liver, pancreas or pancreas/kidney transplant from a donor to a transplant recipient. 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 include 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.

Whenever a heart, 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 Blue Cross and Blue Shield approved Additional Transplant Coverage Programs. No benefits will be provided for Additional Transplants performed at any Hospital that does not have a Blue Cross and Blue Shield approved Additional Transplants Coverage Program.

BENEFIT PAYMENT FOR OTHER COVERED SERVICES

After you have met your deductible, benefits will be provided at 80% of the Eligible Charge or Usual and Customary Fee for any of the other Covered Services described in this Benefit Section.

RIGHT TO APPEAL

If you or your Physician disagree with the recommendations of the Medical Services Advisor prior to receiving services, you may appeal that decision by contacting the MSA Unit or the Blue Cross and Blue Shield Medical Department.

If your admitting Physician's request for an extension of the assigned length of stay is denied on the basis that continued hospitalization is not Medically Necessary, and you disagree with the Medical Services Advisor's decision, you may appeal that decision by following the procedures for Claim Review in the section of this Policy entitled "How To File A Claim." In most instances, the resolution of the appeal process will not occur until your assigned length of stay has elapsed. You must exercise your right to this appeal as a precondition to the taking of any further action against Blue Cross and Blue Shield, either at law or in equity.

FAILURE TO COMPLY WITH MSA RECOMMENDATIONS

The final decision regarding your Inpatient course of treatment is solely your responsibility and the Medical Services Advisor will not interfere with your relationship with any Hospital or Physician. However, Blue Cross and Blue Shield has established the office of the Medical Services Advisor 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 Medical Services Advisor of a scheduled Inpatient Hospital admission or of an emergency or maternity admission or should you decide not to follow the recommendation of the Medical Services Advisor as previously described, you will then be responsible for the first $1,000 of the Hospital's charges for that Inpatient stay in addition to any deductibles and/or co-payments 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.

INDIVIDUAL BENEFITS MANAGEMENT

In addition to the benefits described in this Policy, if your condition would otherwise require continued long-term care in a Hospital or other health care facility, Blue Cross and Blue Shield may offer you alternative benefits for services rendered by a Participating Provider in accordance with an alternative treatment plan which is approved by you, Blue Cross and Blue Shield, and your Physician.

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 total maximum payment for alternative services shall not exceed the total benefits for which you would otherwise be entitled under this Policy if you did not have the alternative benefits.

You may send a written request to Blue Cross and Blue Shield that you be considered for coverage under the Individual Benefits Management provision. However, Blue Cross and Blue Shield will make the final determination of your eligibility to receive the alternative benefits, but only after approval of the alternative care plan, your Physician and you.

Blue Cross and Blue Shield's election to provide alternative benefits in one instance shall not obligate it to provide the same or similar benefits for you in any other in-

SPECIAL PROGRAMS

Certain Hospitals have an agreement with Blue Cross and Blue Shield to provide these special programs to their patients. If so, they are called Plan Programs. Benefits are available for these programs only if they are Plan Programs.

Description of Special Programs

1. Partial Hospitalization Psychiatric Treatment—You must be admitted to this program within 3 days of discharge from a covered Inpatient Hospital admission.

   To be eligible for this program, your treatment must follow an Inpatient Hospital stay. Your treatment is considered a continuation of that stay.

2. Coordinated Home Care—Benefits will be provided for services under a Coordinated Home Care Program provided that these services would have been available to you as an Inpatient in a Hospital. However, you must be admitted to this program within 72 hours of discharge as an Inpatient in a Hospital or Skilled Nursing Facility.

BENEFIT PAYMENT FOR INPATIENT HOSPITAL COVERED SERVICES

After you have met your deductible, benefits will be provided at 80% of the Hospital's Eligible Charge when you receive Inpatient Covered Services in a Participating Hospital or in a Plan Program of a Participating Hospital.

When you receive Inpatient Covered Services in a Non-Participating Hospital or in a Plan Program of a Non-Participating Hospital, benefits will be provided at 60% of the Hospital's Eligible Charge, after you have met your deductible.

When you receive Inpatient Covered Services in a Non-Plan Hospital, benefits will be provided at 50% of the Hospital's Eligible Charge after you have met your deductible. In addition, you must meet a separate $300 Inpatient Hospital deductible if you are admitted to a Non-Participating Hospital.

If you must be hospitalized in a Non-Plan Hospital immediately following Emergency Accident Care or Emergency Medical Care, benefits will be provided at the Participating 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 Participating 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 the Non-Participating Hospital payment level if you are in a Non-Participating Hospital.

If your condition is life threatening, you will be unable to transfer from a Non-Plan Hospital or Non-Participating Hospital to a Participating Hospital or other Participating Provider. However, when your condition is no longer life threatening, you must transfer to a Participating Provider in order to continue to receive benefits at the Participating Provider payment level.

Shock therapy treatments

Radiation therapy treatments

Chemotherapy

Diagnostic Service—Benefits will be provided 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, 80% of the Usual and Customary Fee will be paid, after you have met your deductible.

Benefits for Emergency Accident Care and Emergency Medical will be provided at 100% of the Usual and Customary Fee. Your deductible will not apply to these services.

Physician for the consultation or you may select any other Physician who has an agreement with Blue Cross and Blue Shield to render such services. Benefits for an additional surgical opinion consultation and related Diagnostic Service will be provided at 100% of the Usual and Customary Fee. 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.

Blue Cross and Blue Shield shall not in any event be liable for any act or omission of any Physician or any agent or employee of the Physician including, but not limited to, a failure or refusal for any reason to render services to you or for providing or not providing you with the name of a particular Physician for the consultation.

Medical Care

Benefits are available for Medical Care visits when:

1. you are an Inpatient in a Hospital, a Skilled Nursing Facility, or Substance Abuse Treatment Facility or
2. you are a patient in a Partial Hospitalization Psychiatric Treatment Program or Coordinated Home Care Program or
3. you visit your Physician's office or your Physician comes to your home (except that no benefits are available for psychiatric care).

No benefits are available under this Benefit Section for the Outpatient treatment of Mental Illness or Outpatient Substance Abuse Treatment (these benefits are described in the SPECIAL CONDITIONS AND PAYMENTS section of this Policy). In addition, the Inpatient treatment of Mental Illness and Substance Abuse are subject to the maximums specified in the SPECIAL CONDITIONS AND PAYMENTS section.

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.

Wellness Care

If you are under age 16, benefits will be provided for the following Covered Services when rendered to you by a Physician, even if you are not ill:

- immunizations;
- physical examinations;

Benefits for Wellness Care will be provided at 50% of the Usual and Customary Fee, limited to a maximum of $250 per benefit period. Wellness Care benefits are not subject to your deductible.

In order to identify which Hospitals and facilities are Plan and Non-Plan, please call Blue Cross and Blue Shield at the following toll free number:

1-800-852-5890

OUTPATIENT HOSPITAL CARE

You are entitled to the following benefits when you receive services from a Hospital as an Outpatient.

Outpatient Covered Services

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 you are an Outpatient and 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

BENEFIT PAYMENT FOR OUTPATIENT HOSPITAL COVERED SERVICES

After you have met your deductible, benefits will be provided at 80% of the Hospital's Eligible Charge when you receive Outpatient Covered Services in a Participating Hospital.

When you receive Outpatient Covered Services in a Non-Participating Hospital, benefits will be provided at 60% of the Hospital's Eligible Charge, after you have met your deductible.

When you receive Outpatient Covered Services in a Non-Plan Hospital, benefits will be provided at 50% of the Hospital's Eligible Charge (after you have met your deductible).

However, benefit payment for Emergency Accident Care or Emergency Medical Care will be provided at 100% of the Hospital's Eligible Charge in either a Participating, Non-Participating or Non-Plan Hospital. Your deductible will not apply to Emergency Accident Care or Emergency Medical Care.

WHEN SERVICES ARE NOT AVAILABLE IN A PARTICIPATING HOSPITAL

If you must receive Hospital Covered Services which Blue Cross and Blue Shield

has reasonably determined as unavailable in a Participating Hospital, benefits for the Covered Services you receive in a Non-Participating Hospital will be provided at the payment level described for a Participating Hospital.

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. 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.

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 by a Physician other than the operating surgeon.
3. Assistant Surgery—Services by 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, who has an agreement with Blue Cross and Blue Shield to provide such services. In order to obtain an additional surgical opinion, you must contact the Additional Surgical Opinion Referral Center before you enter a Hospital or Ambulatory Surgical Facility for elective Surgery. The Center will furnish the names of three Physicians, among whom you may select one

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:

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

Hugo Tagli Jr.
Secretary

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 Tagli Jr.
Secretary

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

President

RIDER REGARDING BENEFIT CHANGES

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

Changes to your Coverage

1. The Definition of Partial Hospital Psychiatric Treatment Program in the **Definitions Section** of your Certificate or Policy is hereby amended in its entirety to read as follows:

   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.

2. The benefit description of Partial Hospitalization Psychiatric Treatment in the **Hospital Section** of your Certificate or Policy is hereby amended in its entirety to read as follows:

   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 received in a Non-Plan Partial Hospitalization Treatment Program.

   In order to receive maximum benefits, you must contact the Medical Services Advisor (MSA) prior to receiving services in a Partial Hospitalization Treatment Program. Should you fail to so contact the MSA, the FAILURE TO COMPLY WITH MSA RECOMMEDATIONS provision of the Medical Services Advisory Program described in your Certificate or Policy will apply.

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:

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

Hugo Tagli Jr.
Secretary

Raymond R. McCauley
President

RIDER TO THE POLICY REGARDING
EXCLUSIONS AND GENERAL 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

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.

2. GENERAL PROVISIONS

a. The **TIME LIMIT ON CERTAIN DEFENSES** provision in the GENERAL PROVISIONS section of your Policy is amended to read:

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 two 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.

b. 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

RIDER TO THE POLICY REGARDING ADDITIONAL BENEFITS

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

A. DEFINITIONS SECTION

The definition in your Policy for **Emergency Medical Care** 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.

The following definitions are hereby added to the DEFINITIONS section of your Policy:

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

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

B. OTHER COVERED SERVICES

The following provision is hereby added to the OTHER COVERED SERVICES section of your Policy:

- 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 benefit period.

C. SPECIAL CONDITIONS

The following provision is hereby added to the SPECIAL CONDITIONS or SPECIAL CONDITIONS AND PAYMENTS section of your Policy:

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.

D. EXCLUSIONS- WHAT IS NOT COVERED

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

- -Routine Inpatient Hospital nursery charges and the routine Inpatient examination of a newborn when the mother's charges for Maternity Service are not paid under 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.

Attest:

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

Hugo Taglia Jr.

Secretary

Raymond R. McCauley

President

Rider to the Policy Regarding the Health Insurance Portability and Accountability Act of 1996 (HIPAA)
(Applicable to Policy DB-21 HCSC)

In compliance with the Health Insurance Portability and Accountability Act of 1996, the Policy, to which this Rider is attached and becomes a part, is amended as stated below.

The following provision is hereby added to your Policy:

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-21 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.

DEFINITIONS SECTION

The following definitions are hereby added:

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.

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 Security 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;
(x) Section 5(e) of the Peace Corps Act.

COVERAGE AND PREMIUM INFORMATION

TERMINATION OF COVERAGE

The TERMINATION OF COVERAGE provision is hereby deleted.

CONVERSION PRIVILEGE

The first sentence in the CONVERSION PRIVILEGE provision is hereby deleted in its entirety replaced with the following:

Your coverage under this Policy will automatically terminate when you reach the limiting age.

The following provision is hereby added to your Policy:

CERTIFICATE OF CREDITABLE COVERAGE

Upon termination of your coverage under this Policy, you will be issued a Certificate of Creditable Coverage. You may request a Certificate of Creditable Coverage within 24 months of termination of your coverage under 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.

Attest:

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

Secretary

President

RIDER TO THE CERTIFICATE OR POLICY REGARDING OUTPATIENT CONTRACEPTIVE SERVICES AND HOSPICE CARE PROGRAM

The Certificate or 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 for you.

B. PHYSICIAN BENEFITS

The following benefit provision is added to either the Physician Benefit Section or the Major Medical Benefit Section.

Outpatient Contraceptive Services

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

C. OTHER COVERED SERVICES

The Outpatient drugs and medicines provision is amended in its entirety to read follows:

Outpatient drugs and medicines - All drugs and medicines, except drugs used for cosmetic purposes (including, but not limited to, Retin-A/Tretinoin and Minoxidil/Rogaine) which require by law a written prescription and which are dispensed by a Pharmacy or Physician. In addition, your coverage includes benefits for insulin and insulin syringes even though a prescription may not be required by law.

D. 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.

E. EXCLUSIONS

The following exclusion is added:

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

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 D. McCaskey

President

RIDER TO THE CERTIFICATE OR POLICY REGARDING BLUE CROSS AND BLUE SHIELD'S SEPARATE FINANCIAL ARRANGEMENTS WITH PRESCRIPTION DRUG PROVIDERS

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

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

Blue Cross and Blue Shield's 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 Certificate or 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.

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. Neither the Group, if applicable, nor you are 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 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 P. McCaskey

President

RIDER TO THE POLICY

Effective Date: 01/01/2012

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

EXCLUSIONS—WHAT IS NOT COVERED

The Investigational Services and Supplies exclusion under the EXCLUSIONS—WHAT IS NOT COVERED section of your Policy is revised to read as follows:

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

Grandfathered Health Plan Disclosure

This health insurance issuer believes this coverage is a "grandfathered health plan" under the Affordable Care Act. As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that the policy may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime dollar limits on benefits for any individual.

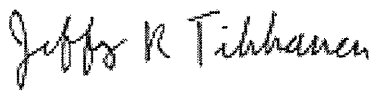
Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to:

Blue Cross and Blue Shield of Illinois
P. O. Box 3236
Naperville, Illinois 60566

You may also contact the U.S. Department of Health and Human Services at www.healthreform.gov.

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 of Illinois,
a Division of Health Care Service Corporation,
a Mutual Legal Reserve Company



Jeffrey R. Tikkanen
President, Retail Markets

RIDER TO THE POLICY

Effective Date: 06/01/2011

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

A. WARNING, LIMITED BENEFITS WILL BE PAID WHEN NON-PARTICIPATING PROVIDERS ARE USED

The **WARNING, LIMITED BENEFITS WILL BE PAID WHEN NON-PARTICIPATING PROVIDERS ARE USED** provision is revised to read as follows:

WARNING, LIMITED BENEFITS WILL BE PAID WHEN NON-PARTICIPATING PROVIDERS ARE USED

You should be aware that when you elect to utilize the services of a Non-Participating Provider for a Covered Service in non-emergency situations, benefit payments to such Non-Participating Provider are not based upon the amount billed. The basis of your benefit payment will be determined according to your policy's fee schedule, usual and customary charge (which is determined by comparing charges for similar services adjusted to the geographical area where the services are performed), or other method as defined by the policy. YOU CAN EXPECT TO PAY MORE THAN THE COINSURANCE AMOUNT DEFINED IN THE POLICY AFTER THE PLAN HAS PAID ITS REQUIRED PORTION. Non-Participating Providers may bill members for any amount up to the billed charge after the plan has paid its portion of the bill as provided in Section §562.3 of the Illinois Insurance Code. Participating Providers have agreed to accept discounted payments for services with no additional billing to the member other than Coinsurance and Deductible amounts. You may obtain further information about the participating status of Professional Providers and information on out-of-pocket expenses by calling the toll-free telephone number on your identification card.

B. PHYSICIAN BENEFIT SECTION

The following provisions are added to the **Non-Participating Provider** payment level under **BENEFIT PAYMENT FOR PHYSICIAN SERVICES**:

When you receive Covered Services, from a Participating Hospital or from a Plan Ambulatory Surgical Facility and, due to any reason, Covered Services for anesthesiology, pathology, radiology, neonatology or emergency room are unavailable from a Participating Provider and Covered Services are provided by a Non-Participating Provider, you will incur no greater out-of-pocket costs than you would have incurred if the Covered Services were provided by a Participating Provider.

However, in the event that you willfully choose to receive Covered Services from a Non-Participating Provider when a Participating Professional Provider is available, or you or the Non-Participating Provider reject the assignment of benefits, the above provision will not apply to you.

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 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.

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

Jeffrey R. Tikkanen
President, Retail Markets

BLUE CROSS AND BLUE SHIELD OF ILLINOIS (POLICY DB-21 HCSC)

Children's Major Medical

OUTLINE OF COVERAGE

BlueCross BlueShield of Illinois

1. Read Your Policy Carefully — This outline of coverage provides a very 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. Major Medical Expense Coverage — Coverage is provided for hospitalization; emergency care; outpatient services; doctor visits; prescription medications; lab and allergy tests; well-child care; physical, occupational, and speech therapies; and psychiatric and substance abuse care, subject to any deductibles, co-payment provisions, or other limitations which may be set forth in the policy.

BENEFITS	PARTICIPATING PROVIDER COVERAGE
LIFETIME MAJOR MEDICAL COVERAGE	$1,000,000.00
ADDITIONAL HUMAN ORGAN TRANSPLANT PROGRAM	$1,000,000.00
INPATIENT AND OUTPATIENT HOSPITAL SERVICES	80%
MEDICAL/SURGICAL SERVICE (inpatient and outpatient)	80%
PHYSICIAN OFFICE AND/OR HOME VISITS (including lab and allergy tests)	80%
PRESCRIPTION DRUGS	80%
OTHER COVERED SERVICES Services of a registered physical, occupational, or speech therapist ($3,000.00 per calendar year for each*); chiropractic services ($1,000.00 per calendar year*); durable medical equipment; ambulance service; artificial limbs and other prosthetic devices; oxygen and its administration; blood plasma; private-duty nursing ($1,000.00 per month maximum*); leg, arm, back, and neck braces; surgical dressings; and casts and splints.	80%
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 consultation and related diagnostic service by a physician.	100%
MENTAL HEALTH AND SUBSTANCE ABUSE CARE Maximum lifetime benefit of $10,000.00.	
Inpatient care limited to $1,000.00 per calendar year*	50%
Outpatient care limited to $500.00 per calendar year*	50%
WELL-CHILD CARE Services provided by a physician to children under age 16 for immunizations and physical examinations. Deductible does not apply. ($250.00 calendar year limit)	50%
BASIC PROVISIONS	
DEDUCTIBLE Per individual per calendar year.	$250.00
CARRYOVER DEDUCTIBLE If an insured incurs a covered expense for the deductible during the last three (3) months of the calendar year, we'll carry over a credit for that part of the deductible to the following calendar year.	
PARTICIPATING PROVIDER HOSPITAL DEDUCTIBLE Per admission, per individual.	$0
OUT-OF-POCKET EXPENSES The maximum amount of money an individual pays toward covered hospital and medical expenses during any one calendar year, excluding the deductibles. Medical Services Advisory copayment, charges in excess of Usual and Customary Allowances, and items asterisked (*) do not apply to any out-of-pocket limit.	$1,000.00
PRE-EXISTING CONDITIONS WAITING PERIOD Upon acceptance, there is no waiting period before benefits are paid for pre-existing conditions listed on the application.	

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

Outline of Coverage

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

A $300-per-admission, per-individual deductible will apply in addition to the primary deductible.* The non-participating provider out-of-pocket expense limit is $5,000, and inpatient and outpatient hospital services are covered at 60%.

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

MEDICAL SERVICES ADVISORY (MSA®′)

Notification is required prior to all elective admissions; emergency admissions require notification within two working days of admission. If notification is not given or MSA advice is not followed, hospital benefits may be reduced by $1,000.00.

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-21 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.

PREMIUMS

We may change premium rates only if we do so on a class basis for all DB-21 HCSC policies. Premiums can be changed based on age, sex, and rating area.

PRE-EXISTING CONDITIONS LIMITATION

Upon acceptance, there is no waiting period before benefits are paid for pre-existing conditions listed on the application. For pre-existing conditions not listed on the application, there is a 365 day waiting period.

Exclusions and Limitations

Services and supplies for or related to the following are not covered: those determined by Blue Cross to be "not medically necessary;" not specifically mentioned in the policy; provided or available under Workers' Compensation or similar laws; furnished or reimbursable by local, state, or federal government; illness or injury caused as a result of war or an act of war; those that do not meet accepted standards of medical practice; investigational services and supplies; custodial care services; routine physical examinations, unless specifically stated in the policy; 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; those received from a dental or medical department or clinic maintained by an employer, labor union or other similar person or group; those for which you are not required to make payment; charges for failure to keep a scheduled visit or complete a claim form; personal hygiene, comfort or convenience items; special braces, splints, specialized equipment, appliances, ambulatory apparatus, battery or atomically controlled implants; 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; flatfoot conditions, subluxations of the foot, or routine foot care; immunizations, unless specifically stated in the policy; maintenance occupational, physical, and 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, unless otherwise stated in the Policy; 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; human organ or tissue transplants other than cornea, kidney, bone marrow, heart valve, muscular-skeletal or parathyroid human organ or tissue transplants, unless otherwise specified in the policy; 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; and maternity service, including related services and supplies.

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

DIRECT MARKETS

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

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
Secretary

Patricia A Hemingway Hall

Patricia A. Hemingway Hall
President and CEO

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

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

Patricia A. Hemingway Hall

President

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

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

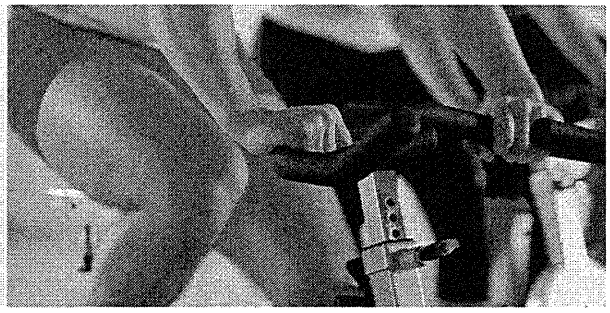
Download the free Provider Finder® App for Android or iPhone

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.

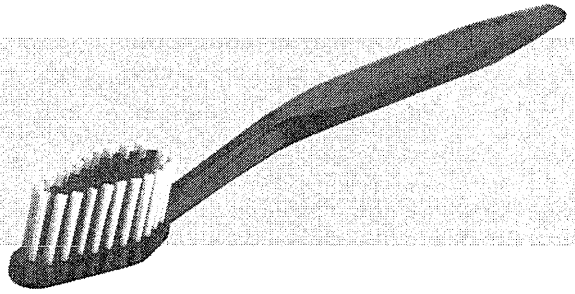
Well onTarget includes wellness programs such as:

- 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.

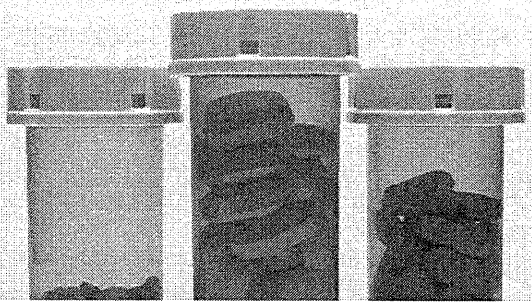
** Proof of Blue Cross and Blue Shield of Illinois coverage is needed. The $0 enrollment fee offer is only for new members who enroll online at www.Blue365Deals.com/BCBSIL/. A $35 administrative fee applies to all memberships. Monthly dues and taxes may also apply. Members' prices, dues and fees may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

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):

Yes ☐
No ☐

- 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.

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.

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

Jeffrey R. Tikkanen
President, Retail Markets

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 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

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

BlueCross BlueShield
of Illinois

HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

Our Responsibilities

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

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

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

Uses and Disclosures of Protected Health Information

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

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

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

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

We may also in our health care operations disclose PHI to business associates[1] with whom we have written agreements containing terms to protect

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

the privacy of your PHI. We may disclose your PHI to another entity that is subject to the federal Privacy Rules and that has a relationship with you for its health care operations relating to quality assessment and improvement activities, reviewing the competence or qualifications of health care professionals, case management and care coordination, or detecting or preventing healthcare fraud and abuse.

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

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

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

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

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

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

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

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

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

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

- *HIV Test Information.* We may not disclose the result of any HIV test or that you have been the subject of an HIV test unless required by law or the disclosure is to you or other persons under limited circumstances or you have given us written permission to disclose.
- *Genetic Information.* We may not use or disclose your genetic information unless the use or

disclosure is made as required by law or you provide us with written permission to disclose such information.

- *Mental Health Information Records.* We may not disclose your mental health information records except to you and anyone else authorized by law to inspect and copy your mental health information records or you provide us with written permission to disclose.
- *Alcoholism or Drug Abuse Information.* We may not disclose any alcoholism or drug abuse information related to your treatment in an alcohol or drug abuse program unless the disclosure is allowed or required by law or you provide us with written permission to disclose.

Individual Rights

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

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

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

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

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

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

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

Questions and Complaints

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

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

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

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

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

BlueCross BlueShield of Illinois

An Important Notice

About Women's Health and Cancer Rights

The "Women's Health and Cancer Rights Act of 1998" requires that plans covering mastectomies also cover reconstructive surgery following mastectomies.

Specifically, because your Blue Cross and Blue Shield of Illinois health insurance policy covers mastectomies, we also cover the following procedures:

- Reconstruction of the breast on which the mastectomy has been performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prostheses and treatment for physical complications at all stages of mastectomy, including lymphodema, in a manner determined in consultation with the attending physician and the patient

This benefit applies immediately and is subject to the applicable deductible and coinsurance provisions of your coverage.

30094.0404 IL

OMNIBUS RIDER TO THE CERTIFICATE OR POLICY

The Certificate or 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 following definition of **Clinical Professional Counselor** is added replacing any previous definition of the same name:

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

3. The following definition of **Clinical Social Worker** is added replacing any previous definition of the same name:

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

4. The following definition of **CRNA** is added replacing any previous definition of the same name or under the name **Certified Registered Nurse Anesthetist**:

   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.

5. 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.

6. 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.

7. If your Certificate or Policy has a Hospice Care Program benefit, 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.

8. 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.

9. 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.

10. 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.

11. 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.

12. 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.

13. The definition of **Substance Abuse Treatment** or **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. MEDICAL SERVICES ADVISORY PROGRAM

The Medical Services Advisory Program section, if applicable to your Certificate or Policy, is hereby amended. The Pre–Admission Review provision or the Inpatient Hospital Services provision of this section, depending on your Certificate or Policy, is expanded to include the following statement:

> In the event you are not able to notify the Medical Services Advisor or MSA within any time period specified in this section following an emergency admission (or maternity admission, if applicable to your Certificate or Policy), you are required to make such notification as soon as reasonably possible.

C. MENTAL ILLNESS, SUBSTANCE ABUSE TREATMENT AND/OR SUBSTANCE ABUSE REHABILITATION TREATMENT

If services or supplies rendered for Mental Illness, Substance Abuse Treatment and/or Substance Abuse Rehabilitation Treatment are Covered Services under your Certificate or Policy:

1. Your Certificate or Policy is amended to add Clinical Professional Counselor and Clinical Social Worker as eligible providers for the treatment of Mental Illness, Substance Abuse Treatment and/or Substance Abuse Rehabilitation Treatment.
2. If your Certificate or Policy contains a Blue Cross and Blue Shield Mental Health Unit section:
   a. The Pre–Admission Review provision of this section is amended to include the following statement:

      > In the event you are not able to notify the Mental Health Unit within the time period specified in this section following an Emergency Mental Illness Admission, you are required to make such notification as soon as reasonably possible.

   b. The address for Written Appeal under the Appeal Procedure provision is deleted and replaced with the following:

      Appeals Coordinator
      Blue Cross and Blue Shield Mental Health Unit
      P. O. Box 1364
      Chicago, Illinois 60690–1364

D. ANESTHESIA SERVICES

The following **Anesthesia Services** provision is added to the Physician Benefit Section or Major Medical Benefit Section, depending on your Certificate or Policy, 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.

E. PRIVATE DUTY NURSING SERVICE

If **Private Duty Nursing Service** is a Covered Service under your Certificate or Policy, the **Private Duty Nursing Service** provision, except for any benefit maximum which may apply, is hereby amended. The provision, which appears under the Other Covered Services section or Major Medical Benefit Section, depending on your Certificate or Policy, will read as noted below. Any benefit maximum applicable to this Covered Service under your Certificate or Policy is not affected by this change and will remain in full force and effect.

> 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.

F. SKILLED NURSING FACILITY CARE OR INPATIENT SKILLED NURSING FACILITY CARE

Depending on your Certificate or Policy, the **Skilled Nursing Facility Care** provision of the Special Conditions or Special Conditions and Payments section or of the Major Medical Benefit Section; or the **Inpatient Skilled Nursing Facility Care** provision of the Hospital Benefit 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.

G. EXCLUSIONS–WHAT IS NOT COVERED

The **Exclusions – What Is Not Covered** section of your Certificate or 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 Certificate or 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).
   - Services and supplies rendered or provided for human organ or tissue transplants other than those specifically named in this Certificate or Policy.

Except as amended by this Rider, all other 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 Tagli Jr.
Secretary

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

Raymond A. McCarthy
President

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 Taglia Jr.

Secretary

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

Raymond T. McCaskey

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 first paragraph under the "Claim Review Procedures"provision is deleted in its entirety. The following provision is added immediately preceding the "Claim Review Procedures" provision:

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 not been received. (For information regarding assigning benefits, see "Payment of Claims and Assignment of Benefits" provisions in the GENERAL PROVISIONS section of this Policy.)

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:

Brian Van Vlierbergen
Secretary

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

Raymond P. McCarley
President