NOTICE OF APPEAL RIGHTS
(Retain for your records)

If Blue Cross and Blue Shield of Illinois (BCBSIL) has declined your application for health insurance coverage or has issued you a policy with a rider, then this document serves as part of your notice of initial adverse determination. **Contact us at the number below if you need assistance understanding this notice or your adverse determination.**

Any conflicts between the statements below and rights stated elsewhere in this notice (or, if applicable, in your policy), will be resolved so that those rights that are more beneficial to you will apply, unless the law requires otherwise.

Your Internal Appeal Rights

What if I don't agree with this decision? You have a right to appeal an adverse determination. However, you only have 180 days from the date you receive the notice of adverse determination to file an internal appeal. We will provide a full and fair review of your appeal by individuals associated with us, but who were not involved in making the initial adverse determination.

Who may file an internal appeal? You or someone you name to act for you (your authorized representative) may file an appeal. You may designate an authorized representative by completing the necessary forms. For more information on how to do so, contact us at the number on the back of your ID card.

How do I file an internal appeal? You may contact us at the number on the back of your ID card and request an internal appeal or send a written request to:

Blue Cross and Blue Shield of Illinois
P.O. Box 3122
Naperville, Illinois 60566-9744
Phone :(800)538-8833
Fax: (888)235-2936

What if my situation is urgent? If your situation meets the definition of urgent under the law, your review will be conducted within 24 hours from our receipt of your request. An urgent situation is one in which your health may be in serious jeopardy or, in the opinion of your doctor you experience pain that cannot be adequately controlled while you wait for a decision on your appeal. If you believe your situation is urgent, you may request an expedited appeal by following the instructions above for filing an internal appeal.

Can I provide additional information about my claim? Yes, you will be informed about how to supply additional information once you initiate your appeal. You may also have the option of presenting evidence and testimony. In addition, we will provide you with any new or additional evidence, rationale, documents, or information used or relied upon in your adverse determination so you have a reasonable opportunity to respond before a final decision is made.

Can I request copies of information relevant to my claim? Yes, you may request and receive copies relevant to your claim free of charge. For example, upon request, you will receive any applicable diagnosis and treatment codes (and their corresponding meanings) associated with an adverse determination. In addition, if we rely on a rule or guideline in making an adverse determination, we will provide that rule or guideline to you free of charge upon request. You can request copies of this information by contacting us at the number above.

What happens next? If you appeal, we will review our decision and send you a written determination within 30 days of our receipt of your appeal.

Note: Individual plans with an effective date on or after March 23, 2010, will receive only one level of internal review. **Contact us at the number on the back of your ID card if you need assistance in understanding this notice or adverse determination.**

Other Resources to Help You

For questions about your rights, this notice, or for assistance, you can contact the Illinois consumer assistance program at:

Illinois Department of Insurance
100 Randolph Street 9th Floor
Chicago, Illinois 60601
www.insurance.illinois.gov
Telephone: (877)527-9431
Email: DOI.Director@illinois.gov

You may be eligible to receive your adverse determination and this notice in a language listed below. In addition, you may call us to receive assistance in these languages.

SPANISH (Español): Para asistencia en Español, por favor llame al numero ubicado en la parte posterior de su tarjeta de identificación.

TAGALOG (Tagalog): Upang humingi ng tulong sa Tagalog, paki tawagan ang numero na nakasulat sa inyong kard.

CHINESE (中文): 如果需要中文幫助，請撥打您卡上的電話號碼。

NAVAJO (Dine): Dinék'ehjí áka'a'doowoo ł biniiyé, t'áá shǫǫdi kojį' hodíílnih béésh bee hane'í bi numbo bee nééh o'dólzinígíí biniiyé nanitinígíí bine'dęę' bikáá'.

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.

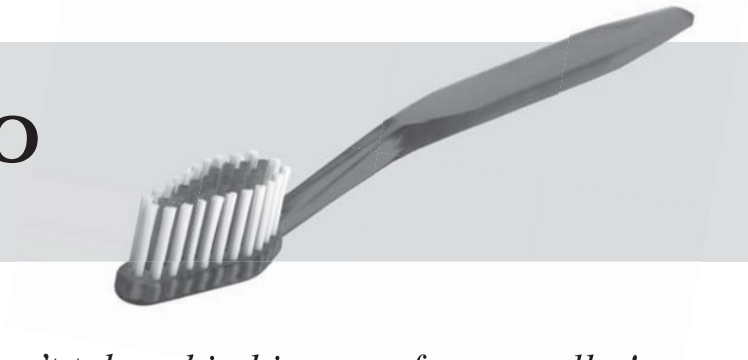
Well onTarget includes wellness programs such as:

- 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

Experience. Wellness. Everywhere.®

ezBlue® PAYMENT OPTION **Authorization Agreement**

Take these simple steps for hassle-free monthly premium payments:

- Verify with your financial institution that it can accept automated electronic withdrawals.
- Complete, sign and return this authorization form.
- If submitting by fax, please fax this form to **1-800-625-5916**.
- If submitting this form by mail, please use this address:

Blue Cross and Blue Shield of Illinois
P.O. Box 3236
Naperville, IL 60566-9708

If you have any questions about this program, please call our Member Service Department toll-free at **1-800-538-8833**.

AGREEMENT

I request and authorize Blue Cross and Blue Shield (BCBS) and/or its designee to obtain payment of amounts becoming due by initiating charges to my account in the form of checks, share drafts, or electronic debit entries, and I request and authorize the Financial Institution named below to accept and honor the same to my account. This authorization will remain in effect until I notify BCBS or the Financial Institution in writing to terminate and BCBS or the Financial Institution has a reasonable time to act on the termination.

Please complete the following - Print or Type information

Deduct ongoing monthly premium payments from my designated checking or savings account. Drafts will be drawn on the Preferred Draft Day specified below. If the draft date falls on a non-business day or a holiday, the premium payment will be deducted from my account on the next business day. (Please note that coverage cannot be issued until the first month of premium has been received in our office, unless you have authorized BCBS to deduct the initial payment upon receipt of your application).

_____ **Preferred Draft Day.** It must be on or prior to the premium due day. If the selected preferred draft day falls after the premium due day, the monthly premium will be drawn on the day premium is due.

BCBS Member ID/Applicant's Social Security Number: _____

Name of Member: _____

Name of Depositor(s) if other than the member: _____

Phone number of Member/Depositor: _____

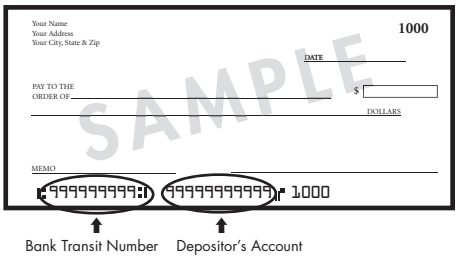
Name of Bank, City and State
where account is authorized: _____

_____

Please check one: ❑ Checking Account ❑ Savings Account

Bank Transit Number: _____

Depositor's Account Number: _____



Bank check – bottom left corner

Bank Transit Number Depositor's Account

I have read and accept the above agreement.

Please continue to pay your premiums by check or money order until you receive a confirmation letter from us stating the date automatic payments will begin.

Depositor's Signature: _____ Date: _____

BlueCross BlueShield of Illinois

Standard Authorization Form To Use or Disclose Protected Health Information (PHI)

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

Name | **Date of Birth**

Group # | **Identification/Subscriber #** | **Social Security Number**

Address | **City** | **State** | **ZIP**

Area Code & Telephone Number

II. Authorization and Purpose:

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

Persons/Organizations authorized to receive your information | **Relationship** | **Purpose**

Address | **City** | **State** | **ZIP**

III. Specific Description of Information to be Used or Disclosed *(Please Complete **Parts A and B** in this Section)*

This Authorization CANNOT be used to disclose Psychotherapy Notes.

A. Release of Sensitive Protected Health Information Under State Law

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

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

Yes ☐

No ☐

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

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

IV. Expiration and Revocation:

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

☐ 24 months 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 these 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 THIS FORM YOU SHOULD KEEP A COPY FOR YOUR RECORDS BY EITHER:

(1) MAKING A PHOTOCOPY OF THIS SIGNED AUTHORIZATION; OR
(2) COMPLETING THE DUPLICATE AUTHORIZATION FORM YOU RECEIVED OR PRINTED

Mail your completed signed authorization to:
Blue Cross and Blue Shield of Illinois
P.O. Box 805107
Chicago, IL 60680-4112

If you need assistance completing the form, please refer to the instructions above or contact the Customer Service number listed on the back of your Member Identification Card.

RIDER TO THE POLICY

Changes in state or federal law or regulations or interpretations thereof may change the terms and conditions of coverage.

This Rider is attached to and become a part of your Policy. The Policy and any Riders thereto are amended as stated below.

A. Policy Year

The following is added to your Policy:

POLICY YEAR

Policy Year means the 12 month period beginning on January 1 of each year.

B. Effective Date

For Policies between in effect on or after March 23, 2010 and before September 23, 2010, this amendment is effective January 1, 2011.

For Policies in effect on or after September 23, 2010, this amendment is effective on the Policy's Coverage Date.

C. Dependent Coverage

Benefits will be provided under this Policy for your and/or your spouse's enrolled child(ren) under the age of 26.

Child(ren), used hereafter, means natural child(ren), stepchild(ren), adopted child(ren) (including child(ren) who are in your custody under an interim court order of adoption or who are placed with you for adoption vesting temporary care), child(ren) for whom you are the legal guardian under 26 years of age, regardless of presence or absence of a child(ren)'s financial dependency, residency, student status, employment status, marital status, or any combination of those factors. If the covered child(ren) are eligible military personnel, the limiting age is 30 years of age.

D. Changing From Individual Coverage to Family Coverage or Adding a Dependent to Family Coverage

The following is added to your Policy:

If you add a dependent 31 days or more after the child's date of birth, adoption or interim court order pending adoption, or obtaining legal guardianship of the child, coverage for such child will be effective on the date of the month which coincides with the Policy Coverage Date, following receipt of the application to add the child.

E. Preexisting Conditions Waiting Period

The Preexisting Conditions waiting period will not apply to you and/or your enrolled family member(s) who are under age 19.

F. Emergency Services

1. The following definition is added to your Policy:

   EMERGENCY SERVICES..... means, with respect to an emergency medical condition, a medical screening examination that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition, and, within the capabilities of the staff and facilities available at the hospital, such further medical examination and treatment as are required to stabilize the patient.

2. Benefits for Emergency Services will be provided without the need for any prior authorization determination and without regard as to whether the health care provider furnishing such services is a Participating Provider. Care provided by a Non-Participating Provider will be paid at no greater cost to you than if the services were provided by a Participating Provider.
3. The following statement is removed in its entirety from the Emergency Accident Care provision throughout your Policy:

   —treatment must occur within 72 hours of the accident or as soon as reasonably possible.

G. Rescissions

The **Your Application For Coverage** provision is deleted in its entirety and replaced with the following:

RESCISSION OF COVERAGE

Any act, practice or omission that constitutes fraud or making an intentional misrepresentation of material fact on the Subscriber's application, will result in the cancellation of your coverage (and/or your dependent(s) coverage) retroactive to the effective date, subject to 30 days' prior notification. Rescission is defined as a cancellation or discontinuance of coverage that has a retroactive effect. In the event of such cancellation, Blue Cross and Blue Shield may deduct from the premium refund any amounts made in Claim Payments during this period and you may be liable for any Claim Payment amount greater than the total amount of premiums paid during the period for which cancellation is effected.

At any time when Blue Cross and Blue Shield is entitled to rescind coverage already in force, Blue Cross and Blue Shield may at its option make an offer to reform the Policy already in force. This reformation could include, but not be limited to, the addition of exclusion riders, (this limitation does not apply to enrolled children under 19 years of age) and a change in the rating category/level. In the event of reformation, the Policy will be reissued retroactive in the form it would have been issued had the misstated or omitted information been known at the time of application. Please refer to the appeals sections of your Policy for your appeal concerning rescission and/or reformation.

H. Preventive Care Services

The following provision is added to your Policy:

PREVENTIVE CARE SERVICES

Benefits will be provided for preventive care services as described below and will not be subject to any Deductible, Coinsurance, Copayment or dollar maximum:

a. evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force ("USPSTF");

b. immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention ("CDC") with respect to the individual involved;

c. evidenced-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration ("HRSA") for infants, children, and adolescents; and

d. with respect to women, such additional preventive care and screenings, not described in item a above, as provided for in comprehensive guidelines supported by the HRSA.

For purposes of this benefit, the current recommendations of the USPSTF regarding breast cancer screening and mammography and prevention will be considered the most current (other than those issued in or around November 2009).

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

Examples of preventive care services included are: routine physical, immunizations, well child care, cancer screening mammograms, bone density test, screening for prostate cancer and colorectal cancer, smoking cessation counseling services and healthy diet counseling and obesity screening/counseling.

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

Preventive care services, as described above, received from a Non-Participating Provider or from a Non-Plan Provider or other routine Covered Services not provided for under this provision will be provided at the same payment level as previously described under the Outpatient Hospital Covered Services and Physician COVERED SERVICES provisions of this Policy.

Preventive care services, as described above, received from a Non-Participating Provider or from a Non-Plan Provider or other routine Covered Services not provided for under this provision will may be subject to the Deductible, Coinsurance, Copayments and/or benefit maximum as described under the Well Child Care and/or WELLNESS CARE provisions of this Policy.

I. Lifetime Maximums

The Lifetime Benefit Maximum provision as listed in the **BENEFIT HIGHLIGHTS** section and the **LIFETIME MAXIMUM** provision in the **PROGRAM PAYMENT PROVISIONS** section of your Policy are deleted in their entirety.

J. Benefit Maximums

If any of the following Covered Services are mentioned in your Policy, the benefit period dollar maximum is deleted in its entirety:

- Occupational Therapy
- Physical Therapy
- Private Duty Nursing Service

K. Internal Claims Determinations and Appeals Process

Any Claim procedures and claim review procedures described throughout your Policy are deleted in their entirety and replaced with the following:

INITIAL CLAIMS DETERMINATIONS

Blue Cross and Blue Shield will usually process 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 usually notify you, your valid assignee or your authorized representative, when all information required to process a Claim within 30 days of

the Claim's receipt has not been received. (For information regarding assigning benefits, see "Payment of Claims and Assignment of Benefits" provision in the GENERAL PROVISIONS section of your Policy.) If you fail to follow the procedures for filing a pre-service claim (as defined below), you will be notified within 5 days (or within 24 hours in the case of a failure regarding an urgent care/expedited clinical claim [as defined below]). Notification may be oral unless the claimant requests written notification.

If a Claim Is Denied or Not Paid in Full

If a claim for benefits is denied in whole or in part, you will receive a notice from Blue Cross and Blue Shield within the following time limits:

1. For benefit determinations relating to care that is being received at the same time as the determination, such notice will be provided no later than 24 hours after receipt of your claim for benefits.

2. For benefit determinations relating to urgent care/expedited clinical claim (as defined below), such notice will be provided no later than 72 hours after the receipt of your claim for benefits, unless you fail to provide sufficient information. You will be notified of the missing information and will have no less than 48 hours to provide the information. A benefit determination will be made within 48 hours after the missing information is received.

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

3. For non-urgent pre-service claims, within 15 days after receipt of the claim by Blue Cross and Blue Shield. A "pre-service claim" is a non-urgent request for approval that Blue Cross and Blue Shield requires you to obtain before you get medical care, such as Preauthorization or a decision on whether a treatment or procedure is Medically Necessary.

4. For post-service Claims, within 30 days after receipt of the Claim by Blue Cross and Blue Shield. A "post-service claim" is a Claim as defined in the DEFINITIONS SECTION.

   If Blue Cross and Blue Shield determines that special circumstances require an extension of time for processing the claim, for non-urgent pre-service and post-service claims, Blue Cross and Blue Shield shall notify you or your authorized representative in writing of the need for extension, the reason for the extension, and the expected date of decision within the initial period. In no event shall such extension exceed 15 days from the end of such initial period. If an extension is necessary because additional information is needed from you, the notice of extension shall also specifically describe the missing information, and you shall have at least 45 days from receipt of the notice within which to provide the requested information.

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

   a. The reasons for denial;

   b. A reference to the benefit plan provisions on which the denial is based;

   c. A description of additional information which may be necessary to perfect an appeal and an explanation of why such material is necessary;

d. Subject to privacy laws and other restrictions, if any, the identification of the Claim, date of service, health care provider, Claim amount (if applicable), diagnosis, treatment and denial codes with their meanings and the standards used;

e. An explanation of Blue Cross and Blue Shield's internal review/appeals and external review processes (and how to initiate a review/appeal or external review);

f. In certain situations, a statement in non-English language(s) that future notices of Claim denials and certain other benefit information may be available in such non-English language(s);

g. The right to request, free of charge, reasonable access to and copies of all documents, records and other information relevant to the claim for benefits;

h. Any internal rule, guideline, protocol or other similar criterion relied on in the determination, and a statement that a copy of such rule, guideline, protocol or other similar criterion will be provided free of charge on request;

i. An explanation of the scientific or clinical judgment relied on in the determination as applied to claimant's medical circumstances, if the denial was based on medical necessity, experimental treatment or similar exclusion, or a statement that such explanation will be provided free of charge upon request;

j. In the case of a denial of an urgent care/expedited clinical claim, a description of the expedited review procedure applicable to such claims. An urgent care/expedited claim decision may be provided orally, so long as written notice is furnished to the claimant within 3 days of oral notification; and

k. Contact information for applicable office of health insurance consumer assistance or ombudsman.

INQUIRIES AND COMPLAINTS

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

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

Blue Cross and Blue Shield has a team available to assist you with Inquiries and Complaints. Issues may include, but are not limited to, the following:

- Claims
- Quality of care

When your Complaint relates to dissatisfaction with a claim denial (or partial denial), then you have the right to a claim review/appeal as described in the CLAIM APPEAL PROCEDURES.

To pursue a Complaint or an Appeal, You may call **Customer Service** at the number on the back your ID Card or you may write to:

Blue Cross and Blue Shield
P.O. Box 3235
Naperville, Illinois 60566-7235

When you contact Customer Service to pursue an Inquiry or Complaint, you will receive a written acknowledgement of your call or correspondence. You will receive a written response to your Inquiry or Complaint within 30 days of receipt by Customer Service. Sometimes the acknowledgement and the response will be combined. If Blue Cross and Blue Shield needs more information, you will be contacted. If a response to your Inquiry or Complaint will be delayed due to the need for additional information, you will be contacted.

An appeal is an oral or written request for review of an Adverse Benefit Determination (as defined below) or an adverse action by Blue Cross and Blue Shield, its employees or a Participating Provider.

CLAIM APPEAL PROCEDURES - DEFINITIONS

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

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

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

A **"Final Internal Adverse Benefit Determination"** means an Adverse Benefit Determination that has been upheld by Blue Cross and Blue Shield at the completion of the Blue Cross and Blue Shield's internal review/appeal process.

CLAIM APPEAL PROCEDURES

If you have received an Adverse Benefit Determination, you may have your Claim reviewed on appeal. Blue Cross and Blue Shield will review its decision in accordance with the following procedures. The following review procedures will also be used for Blue Cross and Blue Shield (i) coverage determinations that are related to non-urgent care that you have not yet received if approval by Blue Cross and Blue Shield is a condition of your opportunity to maximum your benefits and (ii) coverage determinations that are related to care that you are receiving at the same time as the determination. Claim reviews are commonly referred to as "appeals."

Within 180 days after you receive notice of an Adverse Benefit Determination, you may call or write to Blue Cross and Blue Shield to request a claim review. Blue Cross and Blue Shield will need to know the reasons why you do not agree with the Adverse Benefit Determination. You may call 1-800-538-8833 or send your request to:

Claim Review Section
Blue Cross and Blue Shield
P.O. Box 3235
Naperville, Illinois 60566-7235

In support of your Claim review, you have the option of presenting evidence and testimony to Blue Cross and Blue Shield, by phone or in person at a location of Blue Cross and Blue Shield's

choice. You and your authorized representative may ask to review your file and any relevant documents and may submit written issues, comments and additional medical information within 180 days after you receive notice of an Adverse Benefit Determination or at any time during the Claim review process.

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

Urgent Care/Expedited Clinical Appeals

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

Upon receipt of an urgent care/expedited pre-service or concurrent clinical appeal, Blue Cross and Blue Shield will notify the party filing the appeal, as soon as possible, but no more than 24 hours after submission of the appeal, of all the information needed to review the appeal. Additional information must be submitted within 24 hours of request. Blue Cross and Blue Shield shall render a determination on the appeal within 24 hours after it receives the requested information, but no later than 72 hours after the appeal has been received by Blue Cross and Blue Shield.

Other Appeals

Upon receipt of a non-urgent pre-service or post-service appeal Blue Cross and Blue Shield shall render a determination of the appeal within 3 business days if additional information is needed to review the appeal. Additional information must be submitted within 5 days of the request. Blue Cross and Blue Shield shall render a determination of the appeal within 15 business days after it receives the requested information but in no event more than 30 days after the appeal has been received by Blue Cross and Blue Shield.

If You Need Assistance

If you have any questions about the Claims procedures or the review procedure, write or call Blue Cross and Blue Shield's Headquarters at 1-800-538-8833. Blue Cross and Blue Shield offices are open from 8:00 A.M. to 6:00 P.M., Monday through Friday.

Blue Cross and Blue Shield
P.O. Box 3235
Naperville, Illinois 60566-7235

If you need assistance with the internal claims and appeals or the external review processes that are described below, you may contact the health insurance consumer assistance office or om-

budsman. You may contact the Illinois ombudsman program at1-877-527-9431, or call the number on the back of your ID card for contact information.

Notice of Appeal Determination

Blue Cross and Blue Shield will notify the party filing the appeal, you, and, if a clinical appeal, any health care provider who recommended the services involved in the appeal, orally of its determination followed-up by a written notice of the determination.

The written notice will include:

1. The reasons for the determination;
2. A reference to the benefit plan provisions on which the determination is based, or the contractual, administrative or protocol for the determination;
3. Subject to privacy laws and other restrictions, if any, the identification of the Claim, date of service, health care provider, Claim amount (if applicable), and information about how to obtain diagnosis, treatment and denial codes with their meanings;
4. An explanation of Blue Cross and Blue Shield's external review processes (and how to initiate an external review);
5. In certain situations, a statement in non-English language(s) that future notices of Claim denials and certain other benefit information may be available in such non-English language(s);
6. The right to request, free of charge, reasonable access to and copies of all documents, records and other information relevant to the claim for benefits;
7. Any internal rule, guideline, protocol or other similar criterion relied on in the determination, or a statement that a copy of such rule, guideline, protocol or other similar criterion will be provided free of charge on request;
8. An explanation of the scientific or clinical judgment relied on in the determination, or a statement that such explanation will be provided free of charge upon request;
9. A description of the standard that was used in denying the claim and a discussion of the decision; and
10. Contact information for applicable office of health insurance consumer assistance or ombudsman.

If Blue Cross and Blue Shield's decision is to continue to deny or partially deny your Claim or you do not receive timely decision, you may be able to request an external review of your claim by an independent third party, who will review the denial and issue a final decision. Your external review rights are described in the INDEPENDENT EXTERNAL REVIEW section below.

If an appeal is not resolved to your satisfaction, you may appeal Blue Cross and Blue Shield's decision to the Illinois Department of Insurance. The Illinois Department of Insurance will notify Blue Cross and Blue Shield of the appeal. Blue Cross and Blue Shield will have 21 days to respond to the Illinois Department of Insurance.

The operations of Blue Cross and Blue Shield are regulated by the Illinois Department of Insurance. Filing an appeal does not prevent you from filing a Complaint with Illinois Department of Insurance or keep Illinois Department of Insurance from investigating a Complaint.

The Illinois Department of Insurance can be contacted at:

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

You must exercise the right to internal appeal as a precondition to taking any action against Blue Cross and Blue Shield, either at law or in equity. If you have an adverse appeal determination, you may file civil action in a state or federal court.

INDEPENDENT EXTERNAL REVIEW

You or your authorized representative may make a request for a standard external or expedited external review of an Adverse Determination or Final Adverse Determination by an independent review organization (IRO).

An **"Adverse Determination"** means a determination by Blue Cross and Blue Shield or its designated utilization review organization that an admission, availability of care, continued stay, or other health care service that is a Covered Service has been reviewed and, based upon the information provided, does not meet Blue Cross and Blue Shield's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness, and the requested service or payment for the service is therefore denied, reduced, or terminated. A rescission of coverage is also an Adverse Determination. A rescission does not include a termination of coverage for reasons related to non-payment of premium.

A **"Final Adverse Determination"** means an Adverse Determination involving a Covered Service that has been upheld by Blue Cross and Blue Shield or its designated utilization review organization, at the completion of Blue Cross and Blue Shield's internal grievance process procedures.

1. Standard External Review

You or your authorized representative must submit a written request for an external independent review within 4 months of receiving an Adverse Determination or Final Adverse Determination. You may submit additional information or documentation to support your request for the health care services.

a. Preliminary Review. Within 5 business days of receipt of your request, Blue Cross and Blue Shield will complete a preliminary review of your request to determine whether:

- You were a covered person at the time health care service was requested or provided;
- The service that is the subject of the Adverse Determination or the Final Adverse Determination is a Covered Service under this benefit program, but Blue Cross and Blue Shield has determined that the health care service does not meet Blue Cross and Blue Shield's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness;
- You have exhausted Blue Cross and Blue Shield's internal grievance process (in certain urgent cases, you may be eligible for expedited external review even if you have not filed an internal appeal with Blue Cross and Blue Shield, and, you may also be eligible for external review if you filed an internal appeal but have not received a decision from Blue Cross and Blue Shield within 15 days after Blue Cross and Blue Shield received all required information [in no case longer than 30 days after you first file the appeal] or within 48 hours if you have filed a request for an expedited internal appeal); and

- You have provided all the information and forms required to process an external review.

For external reviews relating to a determination based on treatment being experimental or investigational, Blue Cross and Blue Shield will complete a preliminary review to determine whether the requested service or treatment that is the subject of the Adverse Determination or Final Adverse Determination is a Covered Service, except for Blue Cross and Blue Shield's determination that the service or treatment is experimental or investigational for a particular medical condition and is not explicitly listed as an excluded benefit. In addition, the Physician who ordered or provided the services in question has certified that one of the following situations is applicable:

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

b. Notification. Within 1 business day after completion of the preliminary review, Blue Cross and Blue Shield shall notify you and your authorized representative, if applicable, in writing whether the request is complete and eligible for an external review. If the request is not complete or not eligible for an external review, you shall be notified by Blue Cross and Blue Shield in writing of what materials are required to make the request complete or the reason for its ineligibility. Blue Cross and Blue Shield's determination that the external review request is ineligible for review may be appealed to the Director of the Illinois Department of Insurance ("Director") by filing a complaint with the Director. The Director may determine that a request is eligible for external review and require that it be referred for external review. In making such determination, the Director's decision shall be in accordance with the terms of your benefit program and shall be subject to all applicable laws.

c. Assignment of IRO. If your request is eligible for external review, Blue Cross and Blue Shield shall, within 5 business days (a) assign an IRO from the list of approved IROs; and (b) notify you and your authorized representative, if applicable, of the request's eligibility and acceptance for external review and the name of the IRO.

Upon assignment of an IRO, Blue Cross and Blue Shield or its designated utilization review organization shall, within 5 business days, provide to the assigned IRO the documents and any information considered in making the Adverse Determination or Final Adverse Determination. In addition, you or your authorized representative may, within 5 business days following the date of receipt of the notice of assignment of an IRO, submit in writing to the assigned IRO additional information that the IRO shall consider when conducting the external review. The IRO is not required to, but may, accept and consider additional information submitted after 5 business days. If Blue Cross and Blue Shield or its designated utilization review organization does not provide the documents and information within 5 business days, the IRO may end the external review and make

a decision to reverse the Adverse Determination or Final Adverse Determination. A failure by Blue Cross and Blue Shield or designated utilization review organization to provide the documents and information to the IRO within 5 business days shall not delay the conduct of the external review. Within 1 business day after making the decision to end the external review, the IRO shall notify Blue Cross and Blue Shield, you and, if applicable, your authorized representative, of its decision to reverse the determination.

If you or your authorized representative submitted additional information to the IRO, the IRO shall forward the additional information to Blue Cross and Blue Shield within 1 business day of receipt from you or your authorized representative. Upon receipt of such information, Blue Cross and Blue Shield may reconsider the Adverse Determination or Final Adverse Determination. Such reconsideration shall not delay the external review. Blue Cross and Blue Shield may end the external review and make a decision to reverse the Adverse Determination or Final Adverse Determination. Within 1 business day after making the decision to end the external review, Blue Cross and Blue Shield shall notify the IRO, you, and if applicable, your authorized representative of its decision to reverse the determination.

d. IRO's Decision. In addition to the documents and information provided by Blue Cross and Blue Shield and you, or if applicable, your authorized representative, the IRO shall also consider the following information if available and appropriate:

- Your medical records;
- Your health care provider's recommendation;
- Consulting reports from appropriate health care providers and associated records from health care providers;
- The terms of coverage under the benefit program;
- The most appropriate practice guidelines, which shall include applicable evidence-based standards and may include any other practice guidelines developed by the federal government, national or professional medical societies, boards and associations;
- Any applicable clinical review criteria developed and used by Blue Cross and Blue Shield or its designated utilization review organization;
- The opinion of the IRO's clinical reviewer or reviewers after consideration of the items described above, for a denial of coverage based on a determination that the health care service or treatment recommended or requested is experimental or investigational, whether and to what extent (a) the recommended or requested health care service or treatment has been approved by the federal Food and Drug Administration, (b) medical or scientific evidence or evidence-based standards demonstrate that the expected benefits of the recommended or requested health care service or treatment would be substantially increased over those of available standard health care services or treatments, or (c) the terms of coverage under your benefit program to ensure that the health care services or treatment would otherwise be covered under the terms of coverage of your benefit program.

  Within 5 days after the date of receipt of the necessary information, the IRO will render its decision to uphold or reverse the Adverse Determination or Final Adverse Determination. The IRO is not bound by any claim determinations reached prior to the submission of information to the IRO. You and your authorized representative, if applicable, will receive written notice from Blue Cross and Blue Shield. Until July 1, 2013, if you disagree with the determination of the IRO, you may appeal the decision of the IRO to Illinois Department of Insurance at 1-877-527-9431.

The written notice will include:

1. A general description of the reason for the request for external review;
2. The date the IRO received the assignment from Blue Cross and Blue Shield;
3. The time period during which the external review was conducted;
4. References to the evidence or documentation including the evidence-based standards, considered in reaching its decision;
5. The date of its decisions; and
6. The principal reason or reasons for its decision, including what applicable, if any, evidence-based standards that were a basis for its decision.

If the external review was a review of experimental or investigational treatments, the notice shall include the following additional information:

1. A description of your medical condition;
2. A description of the indicators relevant to whether there is sufficient evidence to demonstrate that the recommended or requested health care service or treatment is more likely than not to be more beneficial to you than any available standard health care services or treatments and the adverse risks of the recommended or requested health care service or treatment would not be substantially increased over those of available standard health care services or treatments;
3. A description and analysis of any medical or scientific evidence considered in reaching the opinion;
4. A description and analysis of any evidence-based standards;
5. Whether the recommended or requested health care service or treatment has been approved by the federal Food and Drug Administration;
6. Whether medical or scientific evidence or evidence-based standards demonstrate that the expected benefits of the recommended or requested health care service or treatment is more likely than not to be more beneficial to you than any available standard health care services or treatments and the adverse risks of the recommended or requested health care service or treatment would not be substantially increased over those of available standard health care services or treatments;
7. The written opinion of the clinical reviewer, including the reviewer's recommendation or requested health care service or treatment that should be covered and the rationale for the reviewer's recommendation.

Upon receipt of a notice of a decision reversing the Adverse Determination or Final Adverse Determination, Blue Cross and Blue Shield shall immediately approve the coverage that was the subject of the determination. Benefits will not be provided for services or supplies not covered under the benefit program if the IRO determines that the health care services being reviewed were medically appropriate.

2. Expedited External Review

If you have a medical condition where the timeframe for completion of (a) an expedited internal review of a grievance involving an Adverse Determination; (b) a Final Adverse Determination as set forth in the Illinois Managed Care Reform and Patient Rights Act; or, (c) a standard external review as set forth in the Illinois Health Care External Review Act,

would seriously jeopardize your life or health or your ability to regain maximum function, then you have the right to have the Adverse Determination or Final Adverse Determination reviewed by an IRO not associated with Blue Cross and Blue Shield. In addition, if a Final Adverse Determination concerns an admission, availability of care, continued stay or health care service for which you received emergency services, but have not been discharged from a facility, then you may request an expedited external review.

You may also request an expedited external review if the treatment or service in question has been denied on the basis that it is considered experimental or investigational and your health care provider certifies in writing that the treatment or service would be significantly less effective if not started promptly.

Your request for an expedited independent external review may be submitted orally or in writing.

Notification. Blue Cross and Blue Shield shall immediately notify you and your authorized representative, if applicable, in writing whether the expedited request is complete and eligible for an expedited external review. Blue Cross and Blue Shield's determination that the external review request is ineligible for review may be appealed to the Director by filing a complaint with the Director. The Director may determine that a request is eligible for expedited external review and require that it be referred for an expedited external review. In making such determination, the Director's decision shall be in accordance with the terms of the benefit program and shall be subject to all applicable laws.

Assignment of IRO. If your request is eligible for expedited external review, Blue Cross and Blue Shield shall immediately assign an IRO from the list of approved IROs; and notify you and your authorized representative, if applicable, of the request's eligibility and acceptance for external review and the name of the IRO.

Upon assignment of an IRO, Blue Cross and Blue Shield or its designated utilization review organization shall, within 24 hours provide to the assigned IRO the documents and any information considered in making the Adverse Determination or Final Adverse Determination. In addition, you or your authorized representative may submit additional information in writing to the assigned IRO. If Blue Cross and Blue Shield or its designated utilization review organization does not provide the documents and information within 24 hours, the IRO may end the external review and make a decision to reverse the Adverse Determination or Final Adverse Determination. Within 1 business day after making the decision to end the external review, the IRO shall notify Blue Cross and Blue Shield, you and, if applicable, your authorized representative, of its decision to reverse the determination.

Within 2 business days after the date of receipt of all necessary information, the expedited independent external reviewer will render a decision whether or not to uphold or reverse the Adverse Determination or Final Adverse Determination and you will receive notification from Blue Cross and Blue Shield. Until July 1, 2013, if you disagree with the determination of the external independent reviewer, you may contact the the Illinois Department of Insurance.

The assigned IRO is not bound by any decisions or conclusions reached during Blue Cross and Blue Shield's utilization review process or Blue Cross and Blue Shield's internal grievance process. Upon receipt of a notice of a decision reversing the Adverse Determination or Final Adverse Determination, Blue Cross and Blue Shield shall immediately approve the coverage that was the subject of the determination. Benefits will not be provided for services or supplies not covered under the benefit program if the IRO determines that the health care services being appealed were medically appropriate.

Within 48 hours after the date of providing the notice, the assigned IRO shall provide written confirmation of the decision to you, Blue Cross and Blue Shield and, if applicable, your authorized representative, including all the information outlined under the standard process above.

An external review decision is binding on Blue Cross and Blue Shield. An external review decision is binding on you, except to the extent you have other remedies available under applicable federal or state law. You and your authorized representative may not file a subsequent request for external review involving the same Adverse Determination or Final Adverse Determination for which you have already received an external review decision.

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
President

BlueCross BlueShield of Illinois

BlueEdge℠ Individual HSA
BlueEdge℠ Individual HSA 5000

With Your Choice of Deductibles, Participating Provider Coinsurance Levels, and Provider Networks.

OUTLINE OF COVERAGE

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

2. BlueEdge Individual HSA Coverage — BlueEdge Individual HSA coverage is designed to provide you with economic incentives for using designated health care providers. It provides, to persons insured, coverage for major Hospital, medical, and surgical expenses incurred as a result of a covered accident or sickness. Coverage is provided for daily Hospital room and board, miscellaneous Hospital services, surgical services, anesthesia services,
Inpatient Hospital medical services and Outpatient Hospital care, subject to any deductibles or other limitations which may be set forth in the Policy. **Although you can go to the Hospitals and Physicians of your choice, your benefits under the BlueEdge Individual HSA plan will be greater when you use the services of Participating/In-network Hospitals and Physicians.**

	Participating Provider Coverage	Non-Participating Provider Coverage
Network You must select a network.	PPO Network Blue*Choice*℠ Network	
Individual Coverage Deductible Per calendar year.	$1,250†, $1,750, $2,600, $3.500, $5,000	
Family Coverage Deductible Per calendar year.	Equal to two times the individual deductible	
Hospital Admission Deductible Per admission, per individual.	$0	$300
Coinsurance The level of coverage provided by the plan after the calendar-year Deductible has been satisfied. You must select a level of participating provider coverage 100% participating provider coverage, or 80% participating provider coverage	100% 80%**	80% 60%**
Individual Out-of-Pocket Expense Limit The amount of money an individual pays toward covered hospital and medical expenses during any one calendar year. $5,000 Deductible Option	Calendar year deductible plus $3,000* Your calendar year deductible	Calendar year deductible plus $6,000 Your calendar year deductible plus $5,000
Family Aggregate Out-of-Pocket Expense Limit Equal to two times the individual out-of-pocket limit, per family, per calendar year. $5,000 Deductible Option	Calendar year deductible plus $6,000* Your calendar year deductible	Calendar year deductible plus $12,000 Your calendar year deductible plus $10,000

BASIC PROVISIONS	BlueEdge Individual HSA BlueEdge Individual HSA 5000	
	Participating Provider Coverage	Non-Participating Provider Coverage
Inpatient/Outpatient Physician Medical/Surgical Services	100% 80%**	80% 60%**
Preventive Care Services Benefits will be provided for the following Covered Services and will not be subject to Coinsurance, deductible, Copayment or benefit maximum: Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force (USPSTF); immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and prevention with respect to the individual involved; evidenced-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA) for infants, children, and adolescents; and additional preventive care and screenings provided for in the comprehensive guidelines supported by the HRSA. For purposes of this benefit, the current recommendations of the USPSTF regarding breast cancer screening and mammography and prevention will be considered the most current (other than those issued in or around November 2009).	100%	
Inpatient/Outpatient Hospital Services Includes surgery, preadmission testing and services received in a skilled nursing facility, coordinated home care program and hospice. (For mental health coverage levels, please refer to mental health benefits on the next page.)	100% 80%**	80% 60%**
Inpatient/Outpatient Hospital Diagnostic Services Includes, but not limited to, X-rays, lab tests, EKGs, ECGs, pathology services, pulmonary function studies, radioisotope tests and electromyograms.	100% 80%**	80% 60%**
Physical, Occupational, and Speech Therapist Services	100% 80%**	80% 60%**
Temporomandibular Joint Dysfunction and Related Disorders	100% 80%**	80% 60%**
Muscle Manipulations Rendered by a Physician or Chiropractor ($1,000 per calendar year.)	100% 80%**	80% 60%**
Optional Maternity Coverage Inpatient/Outpatient Hospital services and Physician Medical/Surgical services. *When elected, maternity benefits will begin 365 days after the effective date of the maternity coverage.*	100% 80%**	80% 60%**
Outpatient Emergency Care (Accident or Illness) For both Hospital and Physician.	100% 80%**	
Additional Surgical Opinion Program Following a recommendation for elective surgery, provides additional consultations and related diagnostic service by a Physician, as needed.	100%	80%
Other Covered Services Ambulance services; services of a private duty nursing service; naprapathic services rendered by a Naprapath ($1,000 per calendar-year maximum); oxygen and its administration; blood plasma; surgical dressings; casts and splints.	100% 80%**	

BASIC PROVISIONS	BlueEdge Individual HSA BlueEdge Individual HSA 5000	
	Participating Provider Coverage	Non-Participating Provider Coverage
Outpatient Prescription Drugs	100% 80%**	
Mental Illness Treatment and Substance Abuse Rehabilitation Treatment		
Inpatient Care (30 Inpatient Hospital days per calendar year.)		
Physician	100% 80%**	80% 60%**
Hospital First 14 days	60%	50%
Hospital Thereafter	50%	50%
$5,000 Deductible Option	100%	50%
Outpatient Care (30 visits per calendar year combined annual maximum)		
Physician and Hospital	50%	50%
$5,000 Deductible Option	100%	50%
Medical Services Advisory (MSA*) The MSA helps you maximize your benefits.	The Participating Provider is responsible for notifying MSA when services are rendered in a Participating Hospital.	The Policyholder is responsible for notifying MSA for Hospital admissions at Non-Participating and and Non-Plan Hospitals. MSA notification is required within three business days for non-emergencies and within one business day or as soon as reasonably possible for emergencies and maternity admissions. If Policyholder does not notify MSA, the Policyholder will then be responsible for the first $1,000 or 50% of the Hospital charge, whichever is less.
Mental Health Unit In order to maximize your benefits, the Policyholder is responsible for notifying the Mental Health Unit for ALL care related to mental health and substance abuse. In the event of an admission, for either mental illness or substance abuse, notification is required three days prior for non-emergencies and within 24 hours or as soon as reasonably possible for emergencies. If the Policyholder does not notify the Mental Health Unit, the Policyholder will then be responsible for the first $1,000 or 50% of the Hospital charge, whichever is less.		

Durable Medical Equipment (DME) providers, Orthotic providers and Prosthetic providers are participating providers.
Please refer to your Policy Book for details.

* The individual out-of-pocket expense plus individual deductible can not exceed $5,000. The family aggregate out-of-pocket expense plus family deductible can not exceed $10,000.

** Not available with $5,000 Deductible Option

† The deductible amount will be adjusted automatically if the amount is lower than the amount required by law.

†† Deductible does not apply

IF USING A NON-PLAN PROVIDER... A $300 per Hospital admission Deductible will apply. If using a Non-Plan Provider, benefits are reduced to 50%. However, Outpatient Hospital emergency care is paid at 80% or 100% depending on the plan, regardless of where you receive services.

PRE-EXISTING CONDITIONS LIMITATION Pre-existing Conditions are those health conditions which were diagnosed or treated by a Provider during the 12 months prior to the coverage effective date, or for which symptoms existed which would cause an ordinarily prudent person to seek diagnosis or treatment. Any Pre-existing Condition will be subject to a waiting period of 365 days. This limitation does not apply to dependent children under 19 years of age.

PREMIUMS We may change premium rates only if we do so on a class basis for all DB-50/DB-51/DB-56/DB-57 HCSC policies. Premiums can be changed based on age, sex and rating area.

COST OF LIVING ADJUSTMENT (COLA) The deductible and/or out-of-pocket expense amounts may be adjusted for inflation based on the Consumer Price Index or other index used by the Federal Government and rounded up to the nearest $50 increment.

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 these Policy form numbers, DB-50/DB-51/DB-56/DB-57 HCSC, are 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 these Policy form numbers only on the coverage Renewal Date.

Please be reminded that Health Savings Accounts (HSA) have tax and legal ramifications. Health Care Service Corporation, d/b/a Blue Cross and Blue Shield of Illinois, does not provide legal or tax advice, and nothing herein should be construed as legal or tax advice. Please consult your tax advisors for information regarding the tax consequences of specific health insurance plans or products.

Exclusions and Limitations:

Hospitalization, Services, and supplies which are not Medically Necessary; Services or supplies that are not specifically mentioned in this Policy; Services or supplies for 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 except where not required by law; Services or supplies that are furnished to you by the local, state, or federal government; 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; Investigational Services and Supplies, including all related services and supplies; Custodial Care Service; Routine physical examinations, unless specifically stated in this Policy; Services or supplies received during an Inpatient stay when the stay is primarily related to behavioral, social maladjustment, lack of discipline, or other antisocial actions which are not specifically the result of Mental Illness; Cosmetic Surgery and related services and supplies, except for the correction of congenital deformities or for conditions resulting from accidental injuries, scars, tumors, or diseases; Services or supplies for which you are not required to make payment or would have no legal obligation to pay if you did not have this or similar coverage; Charges for failure to keep a scheduled visit or charges for completion
of a Claim form; Personal hygiene, comfort, or convenience items commonly used for other than medical purposes, such as air conditioners, humidifiers, physical fitness equipment, televisions, and telephones; Special braces, splints, specialized equipment, appliances, ambulatory apparatus, battery controlled implants, except as specifically mentioned in this Policy; Eyeglasses, contact lenses, or cataract lenses and the examinations for prescribing or fitting of glasses or contact lenses or for determining the refractive state of the eye, except as specifically mentioned in this Policy; Treatment of flat foot conditions and the prescription of supportive devices for such conditions and the treatment of subluxations of the foot or routine foot care; Immunizations, unless otherwise stated in this Policy; Maintenance Occupational Therapy, Maintenance Physical Therapy, and Maintenance Speech Therapy, except as specifically mentioned in this Policy; 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 specified in this Policy; Procurement or use of prosthetic devices, special appliances, and surgical implants which are for cosmetic purposes, or unrelated to the treatment of a disease or injury; Services and supplies provided for the diagnosis and/or treatment of infertility including, but not limited to, Hospital services, Medical Care, therapeutic injection, fertility and other drugs, Surgery, artificial insemination, and all forms of in-vitro fertilization; Maternity Service, including related services and supplies, unless selected as an option (Complications of Pregnancy are covered as any other illness);
Long Term Care; Inpatient Private Duty Nursing Service; Maintenance Care; Wigs (also referred to as cranial prosthesis);

Changes in state or federal law, or regulations or interpretations thereof, may change the terms and conditions of coverage.

Notice Regarding Your Benefits

This notice is to inform you that changes have been made to your coverage that may add certain new women's preventive benefits beginning August 1, 2012. The changes are generally outlined below. Blue Cross and Blue Shield of Illinois (BCBSIL) will send you an amendment once it has been approved by the Illinois Department of Insurance.

Women's Preventive Coverage

Certain preventive health services may now be covered with no patient cost-sharing (such as no copayment, coinsurance or deductible) when using a contracting provider within the BCBSIL provider network.

Subject to the terms and conditions of coverage in your policy, these may include:

- Well-woman visits
- Screening for diabetes during pregnancy
- HPV testing for women at least 30 years of age
- Counseling for sexually transmitted infections
- HIV screening and counseling
- FDA-approved contraception methods, sterilization procedures and counseling (see below for more details)
- Breastfeeding support, supplies and counseling
- Interpersonal relations and domestic violence screening and counseling

FDA-approved contraception methods, sterilization procedures and counseling

We may be adding coverage of certain contraceptive medicines, devices and procedures to your policy benefits. They may be covered with no cost-sharing when the services are provided by a BCBSIL network provider. Please note that the coverage of women's contraceptives with no cost-sharing may be limited to certain medicines, devices and procedures within the following categories:

- Designated prescription contraception drugs
- Over-the-counter contraceptives for women (foam, sponge, female condoms) when prescribed by a physician
- Designated medical devices such as certain IUDs, diaphragms, cervical caps and contraceptive implants
- Female sterilization procedures (hysterectomies are not considered part of the women's preventive care benefit as described in this letter)

Please refer to your plan materials or contact us at the phone number on your member ID card for more information. Please remember that the terms and conditions of your policy determine your benefits. In the event of a conflict between this notice and your policy, the policy will supersede this notice.

We appreciate your business and look forward to serving you.

BlueEdge℠ Individual HSA

Your Health Care
Benefits Policy

**BlueCross BlueShield
of Illinois**

DB-56 HCSC

RIGHT TO EXAMINE THIS POLICY

You have the right to examine this Policy for a thirty (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 and identification card(s) to Blue Cross and Blue Shield and void your coverage. Any premium paid to Blue Cross and Blue Shield will be refunded to you, provided that you have not had a Claim paid under this Policy before the end of the thirty (30) day period.

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, DB-56 HCSC, 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.

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 Members of Blue Cross and Blue Shield. The annual meeting is held at our principal office at 300 East Randolph, Chicago, Illinois each year on the last Tuesday in October at 12:30 p.m.

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

A message from

BLUE CROSS AND BLUE SHIELD

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

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

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

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

Sincerely,

Patricia A. Hemingway Hall

President and CEO

Deborah Doman-Rodriguez

Secretary

NOTICE

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

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

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. 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.

TABLE OF CONTENTS

BENEFIT HIGHLIGHTS

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

Additional Surgical Opinion Consultation Payment Level

In-Network . . . . . 100% of the Maximum Allowance, after Deductible

Out-of-Network . . . . . 80% of the Maximum Allowance, after Deductible

Benefit Maximums for

- Private Duty Nursing Service . . . . . $1,000 per month
- Muscle Manipulations . . . . . $1,000 per calendar year
- Naprapathic Service . . . . . $1,000 per calendar year
- Outpatient Speech Therapy . . . . . 30 visits per calendar year
- Outpatient Physical Therapy . . . . . 70 visits per calendar year
- Outpatient Occupational Therapy . . . . . 45 visits per calendar year

Outpatient treatment of Mental Illness and
Outpatient Substance Abuse Rehabilitation Treatment

Combined Calendar Year Benefit Maximum . . . . . 30 visits

Inpatient treatment of Mental Illness and
Inpatient Substance Abuse Rehabilitation Treatment

Calendar Year Benefit Maximum . . . . . 30 Inpatient Days

The Medical Services Advisory Program
MSA®′

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

Notification to the MSA is required before a non-emergency Inpatient Hospital admission Out-of-Network, **subject to a $1,000 Copayment for non-compliance.** Should you fail to notify the MSA as required, you will be responsible for the first $1,000 or 50%, whichever is less, of the Hospital or facility charges. The MSA program does not apply to Covered Services received In-Network in Illinois.

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. All definitions have been arranged in ALPHABETICAL ORDER.

ADVANCED PRACTICE NURSE.....means a Certified Clinical Nurse Specialist, Certified Nurse-Midwife, Certified Nurse Practitioner or Certified Registered Nurse Anesthetist.

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

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

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

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

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

AUDIOLOGIST. . . . . means a duly licensed audiologist.

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

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.

BLUECHOICE®....means a network of selected Providers established by Blue Cross and Blue Shield.

CERTIFIED CLINICAL NURSE SPECIALIST.....means a nurse specialist who (a) is licensed under the Nursing and Advanced Practice Nursing Act; (b) has an arrangement or agreement with a Physician for obtaining medical consultation, collaboration and hospital referral and (c) meets the following qualifications:

(i) is a graduate of an approved school of nursing and holds a current license as a registered nurse; and

(ii) is a graduate of an advanced practice nursing program.

CERTIFIED CLINICAL NURSE SPECIALIST.....means a nurse specialist who (a) is licensed under the Nursing and Advanced Practice Nursing Act; (b) has an arrangement or agreement with a Physician for obtaining medical consultation, collaboration and hospital referral and (c) meets the following qualifications:

(i) is a graduate of an approved school of nursing and holds a current license as a registered nurse; and

(ii) is a graduate of an advanced practice nursing program.

A ''Participating Certified Clinical Nurse Specialist'' means a Certified Clinical Nurse Specialist who 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.

A ''Non-Participating Certified Clinical Nurse Specialist'' means a Certified Clinical Nurse Specialist who does not have 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.

CERTIFIED NURSE-MIDWIFE.....means a nurse-midwife who (a) practices according to the standards of the American College of Nurse-Midwives; (b) has an arrangement or agreement with a Physician for obtaining medical consultation, collaboration and hospital referral and (c) meets the following qualifications:

(i) is a graduate of an approved school of nursing and holds a current license as a registered nurse; and

(ii) is a graduate of a program of nurse-midwives accredited by the American College of Nurse Midwives or its predecessor.

CERTIFIED NURSE PRACTITIONER.....means a nurse practitioner who (a) is licensed under the Nursing and Advanced Practice Nursing Act**;** (b) has an arrangement or agreement with a Physician for obtaining medical consultation, collaboration and hospital referral and (c) meets the following qualifications:

(i) is a graduate of an approved school of nursing and holds a current license as a registered nurse; and

(ii) is a graduate of an advanced practice nursing program.

A ''Participating Certified Nurse Practitioner'' means a Certified Nurse Practitioner who 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.

A ''Non-Participating Certified Nurse Practitioner'' means a Certified Nurse Practitioner who does not have 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.

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

CHEMOTHERAPY.....means the treatment of malignant conditions by pharmaceutical and/or biological antineoplastic drugs.

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

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

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

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

CLINICAL LABORATORY.....means a clinical laboratory which complies with the licensing and certification requirements under the Clinical Laboratory Improvement Amendments of 1988, the Medicare and Medicaid programs and any applicable state and local statutes and regulations.

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

A ''Participating Clinical Professional Counselor" means a Clinical Professional Counselor who 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.

A ''Non-Participating Clinical Professional Counselor" means a Clinical Professional Counselor who does not have 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.

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

A ''Participating Clinical Social Worker" means a Clinical Social Worker who 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.

A ''Non-Participating Clinical Social Worker" means a Clinical Social Worker who does not have 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.

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

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 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.

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

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

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

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

(i) a group health plan;

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

(iii) Medicare (Part A, 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.

(xi) State Children's Health Insurance Program (Title XXI of the Social Security Act).

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.

A "Participating CRNA" means a CRNA who 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.

A "Non-Participating CRNA" means a CRNA who does not have 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.

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.

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

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

DIAGNOSTIC SERVICE.....means tests rendered for the diagnosis of your symptoms and which are directed toward evaluation or progress of a condition, disease or injury. Such tests include, but are not limited to, x-ray,

pathology services, clinical laboratory tests, pulmonary function studies, electrocardiograms, electroencephalograms, radioisotope tests, and electromyograms.

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

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

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

DURABLE MEDICAL EQUIPMENT PROVIDER.....means a duly licensed durable medical equipment provider.

A ''Participating Durable Medical Equipment Provider'' means a Durable Medical Equipment Provider who 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.

A ''Non-Participating Durable Medical Equipment Provider'' means a Durable Medical Equipment Provider who does not have 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.

ELIGIBLE CHARGE.....means (a) in the case of a Provider, other than a Professional 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, other than a Professional 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:

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

(b) 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.

The base Medicare reimbursement rate described above will exclude any Medicare adjustment(s) which is/are based on information on the Claim.

When a Medicare reimbursement rate is not available for a Covered Service or is unable to be determined on the information submitted on the Claim, the 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.

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

EMERGENCY MEDICAL CARE.....means services provided for the initial Outpatient treatment, including related Diagnostic 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.

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

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

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

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

HOME INFUSION THERAPY PROVIDER.....means a duly licensed home infusion therapy provider.

A ''Participating Home Infusion Therapy Provider'' means a Home Infusion Therapy Provider who 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.

A ''Non-Participating Home Infusion Therapy Provider'' means a Home Infusion Therapy Provider who does not have 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.

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

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.

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

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

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

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

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

IN-NETWORK.....means a Covered Service is rendered by a Plan Provider which has a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and Blue Shield Plan or Blue Cross Plan or a Plan facility or Professional Provider which has been designated by a Blue Cross and Blue Shield Plan to provide services to participants in a benefit program that utilizes the BlueChoice network.

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

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

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.

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.

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.

MARRIAGE AND FAMILY THERAPIST ("LMFT").....means a duly licensed marriage and family therapist.

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

MAXIMUM ALLOWANCE.....means (a) the amount which Participating Professional Providers have agreed to accept as payment in full for a particular Covered Service. All benefit payments for Covered Services rendered by Professional Providers In-Network will be based on a Schedule of Maximum Allowances which these Providers have agreed to accept as payment in full. Benefit payments for Covered Services rendered by BlueChoice network Professional Providers will be based upon the applicable BlueChoice payment tier appropriate for that Provider. However, benefit payments for Covered Services rendered by Professional Providers in the PPO network, but not in the BlueChoice network will be based upon the Schedule of Maximum Allowances applicable to the PPO network which these Providers have agreed to accept as payment in full. Benefit payments for Covered

Services rendered by Participating Professional Providers for the treatment of Mental Illness and/or Substance Abuse Rehabilitation Treatment will be based on the Schedule of Maximum Allowances applicable to Managed Care Mental Health and Substance Abuse Rehabilitation Treatment benefits which these Providers have agreed to accept as payment in full. (b) For Professional Providers Out-of-Network, the Maximum Allowance will be the lesser of:

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

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

The base Medicare reimbursement rate described above will exclude any Medicare adjustment(s) which is/are based on information on the Claim.

When a Medicare reimbursement rate is not available for a Covered Service or is unable to be determined on the information submitted on the Claim, the Maximum Allowance for Out-of-Network Professional Providers will be 50% of the Out-of-Network Professional 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 In-Network Professional Provider Claims for processing Claims submitted by Out-of-Network Professional Providers which may also alter the Maximum Allowance 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 Maximum Allowance will not include any additional payments that may be permitted under the Medicare laws or regulations which are not directly attributable to a specific Claim, including, but not limited to, disproportionate share payments and graduate medical education payments.

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

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.C. §1395 et seq.).

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

MENTAL HEALTH UNIT.....means a unit established to perform preadmission review and length of stay review for Inpatient services and/or review of Outpatient services for the treatment of Mental Illness and Substance Abuse.

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

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

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

NON-PARTICIPATING HOSPITAL.....see definition of HOSPITAL

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

OCCUPATIONAL THERAPIST.....means a duly licensed occupational therapist.

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.

A ''Participating Optometrist" means an Optometrist who 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.

A ''Non-Participating Optometrist" means an Optometrist who does not have 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.

ORTHOTIC PROVIDER.....means a duly licensed orthotic provider.

A ''Participating Orthotic Provider" means an Orthotic Provider who 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.

A ''Non-Participating Orthotic Provider" means an Orthotic Provider who does not have 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.

OUT-OF-NETWORK.....means a Covered Service is rendered by a Plan Provider which does not have a written agreement with Blue Cross and Blue Shield of Illinois to provide services to participants in a benefit program that utilizes the BlueChoice network.

OUTPATIENT.....means that you are receiving treatment while not an Inpatient. Services considered Outpatient, include, but are not limited to, services in an emergency room regardless of whether you are subsequently registered as an Inpatient in a health care facility.

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

PARTICIPATING HOSPITAL.....see definition of HOSPITAL

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 THERAPIST.....means a duly licensed physical therapist.

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

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

PHYSICIAN ASSISTANT.....means a duly licensed physician assistant performing under the direct supervision of a Physician, Dentist or Podiatrist and billing under such Provider.

PLAN HOSPITAL.....see definition of HOSPITAL.

PLAN PROVIDER.....see definition of PROVIDER.

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

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

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

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

PROSTHETIC PROVIDER.....means a duly licensed prosthetic provider.

A ''Participating Prosthetic Provider'' means a Prosthetic Provider who 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.

A ''Non-Participating Prosthetic Provider'' means a Prosthetic Provider who does not have 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.

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

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

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

A ''Participating Provider'' means a Plan Hospital, Plan facility or Professional Provider which has a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and Blue Shield Plan or Blue Cross Plan to provide services to participants in a Participating Provider Option program utilizing the BlueChoice network.

A ''Professional Provider'' means a Physician, Dentist, Podiatrist, Psychologist, Chiropractor, Optometrist, Clinical Social Worker or any Provider designated by Blue Cross and Blue Shield of Illinois or another Blue Cross and Blue Shield Plan or Blue Cross Plan

A ''Participating Professional Provider'' means a Professional Provider who 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 participants in a Participating Provider Option program or a Professional Provider who has been designated by a Blue Cross and Blue Shield Plan as a Participating Professional Provider.

A ‘‘Non-Participating Professional Provider’’ means a Professional Provider who does not have 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 participants in a Participating Provider Option program. For purposes of the provision of this Policy entitled “WARNING, LIMITED BENEFITS WILL BE PAID WHEN NON-PARTICIPATING PROVIDERS ARE USED,” a Non-Participating Provider means a Non-Participating Professional Provider.

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

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

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

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

has a doctoral degree from a regionally accredited University, College or Professional School; and has two (2) years of supervised experience in health services of which at least one (1) year is post-doctoral and one (1) year in an organized health services program; or

is a Registered Clinical Psychologist with a graduate degree from a regionally accredited University or College; and has not less than six (6) years as a psychologist with at least two (2) years of supervised experience in health services.

REGISTERED SURGICAL ASSISTANT.....means a duly licensed certified surgical assistant, certified surgical technician, surgical assistant certified or registered nurse first assistant.

A ‘‘Participating Registered Surgical Assistant” means a Registered Surgical Assistant who 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.

A ‘‘Non-Participating Registered Surgical Assistant” means a Registered Surgical Assistant who does not have 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.

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

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

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.

RETAIL HEALTH CLINIC.....means a health clinic located in a retail setting, supermarket or Pharmacy which provides treatment of common illnesses and routine preventive health care services by Certified Nurse Practitioners.

A ‘‘Participating Retail Health Clinic” means a Retail Health Clinic 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.

A ‘‘Non-Participating Retail Health Clinic” means a Retail Health Clinic which does not have 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.

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.

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.

SPEECH THERAPIST.....means a duly licensed speech therapist.

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

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

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

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

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

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

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

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

COVERAGE AND PREMIUM INFORMATION

POLICY YEAR
Policy Year means the 12 month period beginning on January 1 of each year.

RESCISSIONS
Any fraudulent misstatements or omissions, or intentional misrepresentation of a material fact on your application, or any act or practice that constitutes fraud will result in the cancellation of your coverage (and/or your dependent(s) coverage) retroactive to the Coverage Date, subject to prior notification. You have the right to appeal this cancellation and an independent third party may review the decision. In the event of such cancellation, Blue Cross and Blue Shield may deduct from the premium refund any amounts made in Claim payments during this period and you may be liable for any Claims payment amount greater than the total amount of premiums paid during the period for which cancellation is effected.

At any time when Blue Cross and Blue Shield is entitled to rescind coverage already in force, Blue Cross and Blue Shield may at its option make an offer to reform the policy already in force. This reformation could include, but not be limited to, the addition of exclusion riders, (this limitation does not apply to enrolled children under 19 years of age) and a change in the rating category/level. In the event of reformation, the Policy will be reissued retroactive in the form it would have been issued had the misstated or omitted information been known at the time of application.

YOUR BLUE CROSS AND BLUE SHIELD ID CARD
You will receive a Blue Cross and Blue Shield identification card. This card will tell you your Blue Cross and Blue Shield identification number and will be very important to you in obtaining your benefits.

YOUR SCHEDULE PAGE
A Schedule Page has been inserted into and is part of this Policy. The Schedule Page contains specific information about your coverage including, but not limited to: (1) whether you have Individual Coverage or Family Coverage; (2) the amount of your Deductible(s); (3) the hospital and physician benefit payment levels; and (4) the premium amount and the method of payment.

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

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

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.

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

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

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

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

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

This coverage does not include benefits for grandchildren (unless such children are under your legal guardianship) or foster children.

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

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

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

Evidence of Insurability is not required to add a dependent child if application is made to add the child within 31 days of the date of the child's birth or adoption or date of interim court order pending adoption or date of obtaining legal guardianship. Such child's coverage or your Family Coverage will be effective as of the date of birth, adoption, court order, or obtaining legal guardianship.

If you add a dependent 31 days or more after the child's date of birth, adoption or interim court order pending adoption, or obtaining legal guardianship of the child, coverage for such child will be effective on the date of the month which coincides with the policy Coverage Date, following receipt of the application to add the child. Evidence of Insurability is required.

CHANGING FROM FAMILY TO INDIVIDUAL COVERAGE

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

OTHER COVERAGE CHANGES

Divorce

If you become divorced while you have Family Coverage under this Policy, your covered spouse is entitled to have issued to him or her, without Evidence of Insurability, and within 60 days following the entry of the divorce decree as long as there has been no lapse in coverage, a new Policy of the same type. Your dependent children may either continue coverage under your Policy, become covered under your spouse's new Policy or change to separate Individual Coverage Policies (but only if you and your spouse have both elected Individual Coverage). Any Preexisting Conditions waiting period applicable to the new policy(ies) shall be considered as being met to the extent that such waiting period was satisfied under this Policy.

In the Event of your Death

In the event of your death, your covered spouse is entitled to have issued to him or her, without Evidence of Insurability, a new Policy of the same type. Application for such policy must be made within 60 days of the date of death. Your spouse may elect to continue Family Coverage or change to Individual Coverage. In the event your

spouse elects Individual Coverage and there are also dependent children covered under this Policy, those dependent children are entitled to have issued to each of them, separate Individual Coverage policies, without Evidence of Insurability. Application for such policies must be made within 60 days of the date of death. Any Preexisting Conditions waiting period applicable to the new policy(ies) shall be considered as being met to the extent that such waiting period was satisfied under this Policy.

Loss of Eligibility of Dependent Children

When a covered dependent child becomes ineligible for coverage under this Policy (due to reaching the limiting age) he or she may change to a separate Individual Coverage policy of the same type or with lesser benefits. Evidence of Insurability will not be required and any Preexisting Conditions waiting period applicable to the new policy shall be considered as being met to the extent that such waiting period was satisfied under this Policy. Application for this change must be made within 30 days of the date of reaching the limiting age, marriage, or obtaining full-time employment. If the former dependent child elects to apply for an Individual Coverage policy with greater benefits, Evidence of Insurability will be required.

PAYMENT OF PREMIUMS

1. Premiums are due and payable on the due date, which is dependent upon the method of payment selected. The method of payment you selected is shown on the Schedule Page of this Policy.
2. The initial premium for Individual Coverage is based on your age at the time your coverage begins and the initial premium for Family Coverage is based on your age, your spouse's age and any eligible dependent children at the time coverage is applied for.
3. Blue Cross and Blue Shield may establish a new premium for any of the benefits of this Policy on any of the following dates or occurrences:
    a. any premium due date, provided Blue Cross and Blue Shield notifies you of the new premium amount at least 30 days in advance of such premium due date;
    b. whenever the benefits of this Policy are increased, which may occur whenever required by law or whenever Blue Cross and Blue Shield gives notice of an increase in benefits;
    c. whenever you or your spouse attain an age which results in a change in the premium amount due for that age category of coverage;
    d. whenever the number of persons covered under this Policy is changed;
    e. whenever you move your residence from one geographical rating area to another.
4. If the ages upon which the premium is based have been misstated, an amount which will provide Blue Cross and Blue Shield with the correct premium from your Coverage Date shall be due and payable upon billing or receipt from Blue Cross and Blue Shield.
5. If you fail to pay premiums to Blue Cross and Blue Shield within 31 days of the premium due date, this Policy will automatically terminate. Benefits will not be provided for expenses incurred during this 31 day grace period or thereafter unless the premiums are paid within this period.

REINSTATEMENT

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

The reinstated Policy shall cover only loss resulting from such accidental injury as may be sustained after the date of reinstatement and loss due to such illness as may begin more than 10 days after such date. In all other respects

you will have the same rights as you had under the Policy immediately before the due date of the defaulted premium, subject to any provisions endorsed and attached hereto in connection with reinstatement. Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than 60 days prior to the date of reinstatement.

CERTIFICATE OF CREDITABLE COVERAGE

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

EXTENSION OF BENEFITS IN CASE OF TERMINATION

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

BENEFIT INFORMATION

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

PREEXISTING CONDITION WAITING PERIOD

Your benefits are subject to a Preexisting Condition waiting period of 365 days. The Preexisting Condition waiting period will begin on your Coverage Date for you and your eligible dependents, age 19 and older (If you have Family Coverage) and will continue for 365 days. This Preexisting Condition waiting period will also apply to each dependent age 19 and over, for whom coverage is applied for after your Coverage Date. The Preexisting Condition waiting period for such dependent will begin on the dependent's Coverage Date. Until the Preexisting Condition waiting period has ended, no benefits will be provided for a Preexisting Condition. The Preexisting Condition waiting period does not apply to children under age 19.

Any Certificate of Creditable Coverage you (or your eligible dependents) may have received from any previous health plan or insurer can not be used to reduce the Preexisting Condition waiting period applicable under this Policy.

YOUR DEDUCTIBLES

If you have Individual Coverage, each calendar year you must satisfy a **Deductible** before receiving benefits under this Policy. The amount of your Deductible is shown on the Schedule Page of this Policy. After you have claims for Covered Services in a calendar year which exceed this Deductible amount, your benefits will begin.

If you have Family Coverage, each calendar year your family must satisfy the **family Deductible** before receiving benefits under this Policy. The amount of the family Deductible is shown on the Schedule Page. After your family has satisfied the family Deductible, it will not be necessary for anyone else in your family to meet a Deductible in that calendar year. That is, for the remainder of that calendar year, no other family members will be required to meet the Deductible before receiving benefits. No one is eligible for benefits under Family Coverage until the entire family Deductible amount has been satisfied.

The Deductible amount may be adjusted based on the cost-of-living adjustment determined under the Internal Revenue code and rounded to the nearest $50.

In addition to the Individual Coverage or Family Coverage calendar year Deductible, you must satisfy a separate **$300 Inpatient Hospital Deductible** each time you are admitted to a Hospital Out-of-Network or Non-Plan Hospital.

THE PARTICIPATING PROVIDER OPTION

You have chosen a Blue Cross and Blue Shield Participating Provider Option benefit program for the administration of your Hospital and Physician benefits and all other Covered Services that provides you access to the BlueChoice network. This program of health care benefits is designed to provide you with economic incentives for receiving Covered Services In-Network.

As a participant in this benefit program, a directory of Providers participating in the BlueChoice network will be available to you. You can visit the Blue Cross and Blue Shield of Illinois Web site at *www.bcbsil.com* for a list of Participating Providers. While there may be changes in the network list from time to time, selection of Providers by Blue Cross and Blue Shield will continue to be based upon the range of services, geographic location and cost-effectiveness of care. Notice of changes in the network will be provided to you annually, or as required, to allow you to make selection within the network. However, you are urged to check with your Provider before undergoing treatment to make certain of its participation status. Although you can go to the Hospital or Professional Provider of your choice, benefits under this benefit program will be greater when you receive services In-Network.

MEDICAL SERVICES ADVISORY PROGRAM (MSA)

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

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

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

Note: When you choose to receive Covered Services from an In-Network Provider in Illinois, you will not be responsible for notifying the MSA and the provisions of this MSA PROGRAM section will not apply to you.

The provisions of the MSA PROGRAM section do not apply to the treatment of Mental Illness and Substance Abuse Rehabilitation Treatment. The provisions for the treatment of Mental Illness and Substance Abuse Rehabilitation Treatment are specified in the BLUE CROSS AND BLUE SHIELD MENTAL HEALTH UNIT section of this Policy.

PREADMISSION REVIEW

- **Inpatient Hospital Preadmission Review**

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

  Whenever a nonemergency Inpatient Hospital admission is recommended by your Physician, you must, in order to receive maximum benefits under this Policy, call the MSA. This call must be made at least three (3) business days prior to the scheduling of the Hospital admission and the performance of any preadmission tests.

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

- **Emergency Admission Review**

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

  In the event of an emergency admission, you or someone who calls on your behalf, must, in order to receive maximum benefits under this Policy, notify the MSA no later than one (1) business day or as soon as reasonably possible after the admission has occurred. If the call is made any later than the specified time period, you will not receive maximum benefits.

CASE MANAGEMENT

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

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

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

LENGTH OF STAY/SERVICE REVIEW

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

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

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

MEDICALLY NECESSARY DETERMINATION

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

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

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

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

MSA PROCEDURE

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

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

When you contact the MSA, the MSA:

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

APPEAL PROCEDURE

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

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

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

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 thirty (30) days of the date you asked for a review. Also, during this thirty (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 sixty (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 sixty (60) days may be needed for the review and you will be notified of this during the first sixty (60) day period. In any case, by law, no more than one hundred twenty (120) days can be taken for a review, even at your request.

FAILURE TO NOTIFY

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

Should you fail to notify the MSA as required in the Preadmission Review provision of this section, you will then be responsible for the first $1,000 or 50%, whichever is less, of the Hospital or facility charges for an eligible stay in addition to any Deductibles and/or Coinsurance applicable to this Policy. This amount shall not be eligible for later consideration as an unreimbursed expense under any benefit section of this Policy nor can it be applied to your out-of-pocket expense limit, if applicable to this Policy.

BLUE CROSS AND BLUE SHIELD
MENTAL HEALTH UNIT

The Blue Cross and Blue Shield Mental Health Unit has been established to perform preadmission review and length of stay review for your Inpatient Hospital services for the treatment of Mental Illness and Substance Abuse. The Mental Health Unit is staffed primarily by Physicians, Psychologists, Clinical Social Workers and registered nurses.

Failure to contact the Mental Health Unit or to comply with the determinations of the Mental Health Unit will result in a reduction of benefits. The Mental Health Unit may be reached twenty-four (24) hours a day, seven (7) days a week at the toll-free telephone number 1-800-851-7498. Please read the provisions below very carefully.

PREADMISSION REVIEW

- **Inpatient Hospital Preadmission Review**

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

  Whenever a nonemergency Inpatient Hospital admission for the treatment of Mental Illness or Substance Abuse is recommended by your Physician, you must, in order to receive maximum benefits under this Policy, call the Mental Health Unit. This call must be made three (3) days prior to the scheduling of the Hospital admission and the performance of any preadmission tests.

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

- **Emergency Mental Illness Admission Review**

  Emergency Mental Illness Admission review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of this Policy as well as the Preexisting Condition waiting period, if any.

  In the event of an Emergency Mental Illness Admission, you or someone who calls on your behalf must, in order to receive maximum benefits under this Policy, notify the Mental Health Unit no later than twenty-four (24) hours or as soon as reasonably possible after the admission has occurred. If the call is made any later than the specified time period, you will not be eligible for maximum benefits.

- **Partial Hospitalization Treatment Program Review**

  Partial Hospitalization Treatment Program review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of this Policy as well as the Preexisting Condition waiting period, if any.

  Whenever an admission to a Partial Hospitalization Treatment Program is recommended by your Physician, you must, in order to receive maximum benefits under this Policy, call the Mental Health Unit. This call must be made at least three (3) days prior to the scheduling of the admission.

- **Length of Stay Review**

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

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

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

MEDICALLY NECESSARY DETERMINATION

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

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

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

Remember that your Blue Cross and Blue Shield Policy does not cover the cost of hospitalization or any health care services and supplies that are not Medically Necessary. The fact that your Physician or another health care Provider may prescribe, order, recommend or approve a Hospital stay or other health care service or supply does not of itself make such hospitalization, service or supply Medically Necessary. Even if your Physician prescribes, orders, recommends, approves, or views hospitalization or other health care services or supplies as Medically Necessary, Blue Cross and Blue Shield will not pay for the hospitalization, services or supplies if the Mental Health Unit Physician decides they were not Medically Necessary.

MENTAL HEALTH UNIT PROCEDURE

When you contact the Mental Health Unit, you should be prepared to provide the following information:

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

When you contact the Mental Health Unit, the Mental Health Unit:

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

APPEAL PROCEDURE

Expedited Appeal

If you or your Physician disagree with the determinations of the Mental Health Unit prior to or while receiving services, you or the Provider may appeal that determination by contacting the Mental Health Unit and requesting an expedited appeal. The Mental Health Unit Physician will review your case and determine whether the service was Medically Necessary. You and/or your Provider will be notified of the Mental

Health Unit Physician's determination within twenty-four (24) hours or no later than the last authorized day. If you or your Provider still disagree with the Mental Health Unit Physician, you may request an appeal in writing as outlined below.

Written Appeal

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

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

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 thirty (30) days of the date you asked for a review. Also, during this thirty (30) day period, you may review any pertinent documents held by Blue Cross and Blue Shield, if you request an appointment in writing.

Within sixty (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 sixty (60) days may be needed for the review and you will be notified of this during the first sixty (60) day period. In any case, by law, no more than one hundred twenty (120) days can be taken for a review, even at your request.

FAILURE TO NOTIFY

The final decision regarding your course of treatment is solely your responsibility and the Mental Health Unit will not interfere with your relationship with any Provider. However, the Mental Health Unit has been established for the specific purpose of assisting you in maximizing your benefits provided under this Policy.

Should you fail to notify the Mental Health Unit as required in the Preadmission Review provision of this section, you will then be responsible for the first $1,000 or 50%, whichever is less, of the Hospital charges for an eligible Hospital stay in addition to any Deductibles and/or Coinsurance applicable to this Policy. This amount shall not be eligible for later consideration as an unreimbursed expense under any Benefit Section of this Policy nor can it be applied to your out-of-pocket expense limit.

INDIVIDUAL BENEFITS MANAGEMENT PROGRAM ("IBMP")

In addition to the benefits described in this Policy, if your condition would otherwise require continued care in a Hospital or other health care facility, provision of alternative benefits for services rendered by an In-Network Provider in accordance with an alternative treatment plan may be available to you.

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.

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

HOSPITAL BENEFIT SECTION

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

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

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

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

INPATIENT COVERED SERVICES

Inpatient Hospital Care

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

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

Preadmission Testing

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

Partial Hospitalization Treatment

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

Coordinated Home Care

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

BENEFIT PAYMENT FOR INPATIENT HOSPITAL COVERED SERVICES

After you have met your Deductible, benefits will be provided as described below.

Each time you are admitted to an Out-of-Network Hospital or Non-Plan Hospital you will also be responsible for a $300 Inpatient Hospital Deductible.

In-Network

When you receive Inpatient Covered Services In-Network or in a Coordinated Home Care Program In-Network, benefits will be provided at the In-Network payment level shown on the Schedule Page. If you are in a private room, benefits will be limited by the Hospital's rate for its most common type of room with two or more beds.

Out-of-Network
When you receive Inpatient Covered Services Out-of-Network, benefits will be provided at the Out-of-Network payment level shown on the Schedule Page. If you are in a private room, benefits will be limited by the Hospital's rate for its most common type of room with two or more beds.

Non-Plan Provider
When you receive Inpatient Covered Services from a Non-Plan Provider, benefits will be provided at 50% of the Eligible Charge.

Emergency Admissions
If you must be hospitalized in a Non-Plan Hospital or an Out-of-Network Hospital immediately following Emergency Accident Care or Emergency Medical Care, benefits will be provided at the In-Network 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 serious and therefore not permitting your safe transfer to a Hospital In-Network or other Provider In-Network.

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

In order for you to continue to receive benefits at the In-Network payment level following an emergency admission to a Non-Plan Hospital or Out-of-Network Hospital, you must transfer In-Network as soon as your condition is no longer serious.

TO IDENTIFY NON-PLAN AND PLAN HOSPITALS OR FACILITIES, YOU SHOULD CONTACT BLUE CROSS AND BLUE SHIELD BY CALLING THE CUSTOMER SERVICE TOLL-FREE TELEPHONE NUMBER ON YOUR BLUE CROSS AND BLUE SHIELD IDENTIFICATION CARD. YOU CAN ALSO VISIT THE BLUE CROSS AND BLUE SHIELD WEBSITE AT *WWW.BCBSIL.COM* FOR A LIST OF PROVIDERS PARTICIPATING IN THE BLUECHOICE NETWORK.

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

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

   In addition to Surgery in a Hospital, benefits will be provided for Outpatient Surgery performed in an Ambulatory Surgical Facility.
2. **Radiation therapy treatments**
3. **Chemotherapy**
4. **Electroconvulsive Therapy**
5. **Renal Dialysis Treatments**—these treatments are eligible for benefits if you receive them in a Hospital, a Dialysis Facility or in your home under the supervision of a Hospital or Dialysis Facility.
6. **Diagnostic Service**—when these services are related to Surgery or Medical Care.
7. **Emergency Accident Care**—treatment must occur within 72 hours of the accident or as soon as reasonably possible.
8. **Emergency Medical Care**
9. **Mammograms**
10. **Colorectal Cancer Screening**—Benefits will be provided for colorectal cancer screening as prescribed by a Physician, in accordance with the published American Cancer Society guidelines on colorectal

cancer screening or other existing colorectal cancer screening guidelines issued by nationally recognized professional medical societies or federal government agencies, including the National Cancer Institute, the Centers for Disease Control and Prevention, and the American College of Gastroenterology.

Benefits for colorectal cancer screening will be provided at the benefit payment described in the Wellness Care provision of this 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 Policy.

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

BENEFIT PAYMENT FOR OUTPATIENT HOSPITAL COVERED SERVICES
After you have met your Deductible benefits will be provided as described below:

In-Network
When you receive Outpatient Hospital Covered Services In-Network, benefits will be provided at the In-Network payment level shown on the Schedule Page.

Out-of-Network
When you receive Outpatient Hospital Covered Services Out-of-Network, benefits will be provided at the Out-of-Network payment level shown on the Schedule Page.

Non-Plan Provider
When you receive Outpatient Hospital Covered Services from a Non-Plan Provider, benefits will be provided at 50% of the Eligible Charge.

Emergency Care
After you have met your Deductible, benefits for Emergency Accident Care and Emergency Medical Care will be provided at the In-Network payment level for Outpatient emergency care shown on the Schedule Page whether rendered In-Network, Out-of-Network or from a Non-Plan Provider.

However, Emergency Medical Covered Services for the examination and testing of a victim of criminal sexual assault or abuse to determine whether sexual contact occurred, and to establish the presence or absence of sexually transmitted disease or infection, will be paid at 100% of the Eligible Charge whether or not you have met your Deductible.

WHEN SERVICES ARE NOT AVAILABLE IN-NETWORK (HOSPITAL)
If you must receive Hospital Covered Services which Blue Cross and Blue Shield has reasonably determined as being unavailable from a Provider In-Network, benefits for the Covered Services you receive from a Provider Out-of-Network will be provided at the payment level described for a Provider In-Network.

HOSPICE CARE PROGRAM

Your Hospital coverage also includes benefits for Hospice Care Program Service.

Benefits will be provided for the Hospice Care Program Service described below when these services are rendered to you by a Hospice Care Program Provider. However, for benefits to be available you must have a terminal illness with a life expectancy of one (1) year or less, as certified by your attending Physician; and you will no longer benefit from standard medical care or have chosen to receive hospice care rather than standard care. Also, a family member or friend must be available to provide custodial type care between visits from Hospice Care Program Providers if hospice is being provided in the home.

The following services are covered under the Hospice Care Program:

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

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

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

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

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

PHYSICIAN BENEFIT SECTION

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

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

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

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

COVERED SERVICES

Surgery

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

Benefits provided for oral Surgery (performed by a Physician or Dentist) are limited to the following services:

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

The following services are also part of your surgical benefits:

1. Sterilization Procedures (even if they are elective).
2. Anesthesia–if administered at the same time as a covered surgical procedure in a Hospital or Ambulatory Surgical Facility or by a Physician other than the operating surgeon or by a CRNA. However, benefits will be provided for anesthesia services administered by oral and maxillofacial surgeons when such services are rendered in the surgeon's office or Ambulatory Surgical Facility.

   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.
3. 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.

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. If you

request, benefits will be provided for an additional consultation when the need for Surgery, in your opinion, is not resolved by the first arranged consultation.

Medical Care

Benefits are available for Medical Care visits when:

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

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

Consultations

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

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.

Electroconvulsive Therapy

Radiation Therapy Treatments

Chemotherapy

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

Colorectal Cancer Screening—Benefits will be provided for colorectal cancer screening as prescribed by a Physician, in accordance with the published American Cancer Society guidelines on colorectal cancer screening or other existing colorectal cancer screening guidelines issued by nationally recognized professional medical societies or federal government agencies, including the National Cancer Institute, the Centers for Disease Control and Prevention, and the American College of Gastroenterology.

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

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.

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.

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

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

Emergency Medical Care

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 a maximum of $1,000 per calendar year.

Leg, Back, Arm and Neck Braces

Prosthetic Appliances
Benefits will be provided for prosthetic devices, special appliances and surgical implants when:

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

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

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

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.

Shingles Vaccine
Benefits will be provided for a shingles vaccine approved by the federal Food and Drug Administration. Benefits will be provided at the benefit payment level described in the Preventive Services provision of this Policy.

Occupational Therapy
Benefits will be provided for Occupational Therapy when these services are rendered by a registered Occupational Therapist under the supervision of a Physician. This therapy must be furnished under a written plan established by a Physician and regularly reviewed by the therapist and Physician. The plan must be established before treatment is begun and must relate to the type, amount, frequency and duration of therapy and indicate the diagnosis and anticipated goals. Benefits for Outpatient Occupational Therapy will be limited to a maximum of 45 visits per calendar year.

Physical Therapy
Benefits will be provided for Physical Therapy when rendered by a registered professional Physical Therapist under the supervision of a Physician. The therapy must be furnished under a written plan established by a Physician and regularly reviewed by the therapist and the Physician. The plan must be established before treatment is begun and must relate to the type, amount, frequency and duration of therapy and indicate the diagnosis and anticipated goals. Benefits 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. Benefits for Outpatient Physical Therapy will be limited to a maximum of 70 visits per calendar year.

Speech Therapy
Benefits will be provided for Speech Therapy when these services are rendered by a licensed Speech Therapist or Speech Therapist certified by the American Speech and Hearing Association. Inpatient Speech Therapy benefits will be provided only if Speech Therapy is not the only reason for admission. Outpatient Speech Therapy benefits will be limited to a maximum of 30 visits per calendar year.

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.

BENEFIT PAYMENT FOR PHYSICIAN SERVICES
The benefits provided by Blue Cross and Blue Shield and the expenses that are your responsibility for your Covered Services will depend on whether you receive services In-Network or Out-of-Network and whether services are provided by a Participating or Non-Participating Professional Provider. In most cases, your benefits will be greater when you receive services In-Network.

In-Network

When you receive Covered Services for an additional surgical opinion consultation and related Diagnostic Service In-Network or from a Dentist, benefits will be provided at 100% of the Maximum Allowance, after you have met your Deductible. When you receive any of the other Covered Services described in this Physician Benefit Section from a Participating Professional Provider or from a Dentist, benefits will be provided at the Physician payment level for Participating Providers specified on the Schedule Page, after you have met your Deductible. Dentists are not Participating Professional Providers, but will be treated as such for purposes of benefit payment made under this Policy.

Out-of-Network

When you receive Covered Services for an additional surgical opinion consultation and related Diagnostic Service Out-of-Network, benefits will be provided at 80% of the Maximum Allowance, after you have met your Deductible. When you receive any of the other Covered Services described in this Physician Benefit Section from a Professional Provider Out-of-Network, benefits will be provided at the Physician payment level for Non-Participating Providers specified on the Schedule Page, after you have met your Deductible.

Emergency Care

After you have met your Deductible, benefits for Emergency Accident Care and Emergency Medical Care will be provided at the Participating Providers payment level shown on the Schedule Page when services are rendered either In-Network or Out-of-Network for Outpatient emergency care.

However, Emergency Medical Covered Services for the examination and testing of a victim of criminal sexual assault or abuse to determine whether sexual contact occurred, and to establish the presence or absence of sexually transmitted disease or infection, will be paid at 100% of the Eligible Charge whether or not you have met your Deductible.

Participating Professional Providers are:

- Physicians
- Podiatrists
- Psychologists
- Audiologists
- Certified Nurse-Midwives
- Certified Clinical Nurse Specialists
- Certified Nurse Practitioner

- Durable Medical Equipment Providers
- Home Infusion Therapy Providers
- Chiropractors
- Clinical Social Workers
- Clinical Professional Counselors
- Clinical Laboratories
- CRNAs
- Physical Therapists
- Occupational Therapists
- Optometrists
- Orthotic Providers
- Prosthetic Providers
- Registered Surgical Assistants
- Retail Health Clinics
- Speech Therapists

who have signed an agreement with Blue Cross and Blue Shield to accept the Maximum Allowance as payment in full. Such Participating Professional Providers have agreed not to bill you for Covered Services amounts in excess of the Maximum Allowance. Therefore, you will be responsible only for the difference between the Blue Cross and Blue Shield benefit payment and the Maximum Allowance for the particular Covered Service — that is, your Deductible and Coinsurance amounts.

Non-Participating Professional Providers are:

- Physicians
- Podiatrists
- Psychologists
- Audiologists
- Certified Nurse-Midwives
- Certified Clinical Nurse Specialists
- Certified Nurse Practitioner
- Durable Medical Equipment Providers
- Home Infusion Therapy Providers
- Chiropractors
- Clinical Social Workers
- Clinical Professional Counselors
- Clinical Laboratories
- CRNAs
- Physical Therapists
- Occupational Therapists
- Optometrists
- Orthotic Providers
- Prosthetic Providers

- Registered Surgical Assistants
- Retail Health Clinics
- Speech Therapists
- other Professional Providers

who have not signed an agreement with Blue Cross and Blue Shield to accept the Maximum Allowance as payment in full. Therefore, you are responsible to these Providers for the difference between the Blue Cross and Blue Shield benefit payment and such Provider's charge to you.

Should you wish to know the Maximum Allowance for a particular procedure or whether a particular Professional Provider is a Participating Professional Provider, contact your Professional Provider or Blue Cross and Blue Shield.

OTHER COVERED SERVICES

COVERED SERVICES

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

- Blood and blood components
- 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. Your benefits for Private Duty Nursing Service are limited to a maximum of 4 visits per month.
- Ambulance Transportation—when your condition is such that an ambulance is necessary. Benefits will not be provided for long distance trips or for use of an ambulance because it is more convenient than other transportation.
- 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.
- Dental accident care—dental services rendered by a Dentist or Physician which are required as the result of an accidental injury when caused by an external force. External force means any outside strength producing damage to the dentition and/or oral structures. However, these services are covered only if the injury occurred on or after your Coverage Date.
- Allergy shots and allergy surveys
- Oxygen and its administration
- Medical and surgical dressings, supplies, casts and splints
- Naprapathic Service—Benefits will be provided for Naprapathic Services when rendered by a Naprapath. Benefits for Naprapathic Services will be limited to a maximum of $1,000 per calendar year.
- 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 written prescription and which are dispensed by a Pharmacy or Physician. In addition, your coverage includes benefits for insulin and insulin syringes event though a prescription may not be required by law.

BENEFIT PAYMENT FOR OTHER COVERED SERVICES

After you have met your Deductible, benefits for any Other Covered Services will be provided at the benefit payment levels shown on the Schedule Page.

The expenses that are your responsibility for your Other Covered Services will depend on whether you receive services In-Network or Out-of-Network and whether services are provided by a Participating or Non-Participating Professional Provider.

Participating Professional Providers are:

- Physicians
- Podiatrists
- Psychologists
- Audiologists

- Certified Nurse-Midwives
- Certified Clinical Nurse Specialists
- Certified Nurse Practitioner
- Durable Medical Equipment Providers
- Home Infusion Therapy Providers
- Chiropractors
- Clinical Social Workers
- Clinical Professional Counselors
- Clinical Laboratories
- CRNAs
- Physical Therapists
- Occupational Therapists
- Optometrists
- Orthotic Providers
- Prosthetic Providers
- Registered Surgical Assistants
- Retail Health Clinics
- Speech Therapists

who have signed an agreement with Blue Cross and Blue Shield to accept the Maximum Allowance as payment in full. Such Participating Professional Providers have agreed not to bill you for Covered Services amounts in excess of the Maximum Allowance. Therefore, you will be responsible only for the difference between the Blue Cross and Blue Shield benefit payment and the Maximum Allowance for the particular Covered Service — that is, your Deductible and Coinsurance amounts.

Non-Participating Professional Providers are:

- Physicians
- Podiatrists
- Psychologists
- Audiologists
- Certified Nurse-Midwives
- Certified Clinical Nurse Specialists
- Certified Nurse Practitioner
- Durable Medical Equipment Providers
- Home Infusion Therapy Providers
- Chiropractors
- Clinical Social Workers
- Clinical Professional Counselors
- Clinical Laboratories
- CRNAs
- Physical Therapists
- Occupational Therapists

- Optometrists
- Orthotic Providers
- Prosthetic Providers
- Registered Surgical Assistants
- Retail Health Clinics
- Speech Therapists
- other Professional Providers

who have not signed an agreement with Blue Cross and Blue Shield to accept the Maximum Allowance as payment in full. Therefore, you are responsible to these Providers for the difference between the Blue Cross and Blue Shield benefit payment and such Provider's charge to you.

Should you wish to know the Maximum Allowance for a particular procedure or whether a particular Professional Provider is a Participating Professional Provider, contact your Professional Provider or Blue Cross and Blue Shield.

SPECIAL CONDITIONS

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

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

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

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

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

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

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

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

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

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

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

CARDIAC REHABILITATION

Your benefits for cardiac rehabilitation services are the same as your benefits for any other condition. Benefits will be provided for cardiac rehabilitation services only in Blue Cross and Blue Shield approved programs when these services are rendered to you within a six month period following an eligible Inpatient Hospital admission for either myocardial infarction, coronary artery bypass Surgery, or percutaneous transluminal coronary angioplasty. Benefits will be limited to a maximum of 36 Outpatient treatment sessions within the six month period.

SKILLED NURSING FACILITY CARE

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

(1) Bed, board and general nursing care.

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

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

After you have met your Deductible, benefits will be provided at the In-Network Hospital payment level, shown on the Schedule Page, for Covered Services rendered in a Plan Skilled Nursing Facility. For Covered Services rendered in a Non-Plan Skilled Nursing Facility benefits will be provided at 50% of the Eligible Charge after you have met your Deductible.

AUTISM SPECTRUM DISORDER(S)

Your benefits for the diagnosis and treatment of Autism Spectrum Disorder(s), or 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.

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.

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.

PREVENTIVE SERVICES

Benefits for the following Covered Services will be provided at 100% of the Maximum Allowance or 100% of the Eligible Charge whether services are rendered by a Participating Provider or a Non-Participating Provider. Benefits will not be subject to the Deductible or Copayment.

- evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force ("USPSTF");
- immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved;
- evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration ("HRSA") for infants, children, and adolescents;
- and additional preventive care and screenings provided for in comprehensive guidelines supported by the HRSA.

For purposes of this benefit, the current recommendations of the USPSTF regarding breast cancer screening mammography and prevention will be considered the most current (other than those issued around November 2009).

TREATMENT OF MENTAL ILLNESS AND SUBSTANCE ABUSE REHABILITATION TREATMENT

Treatment of Mental Illness

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

Substance Abuse Rehabilitation Treatment

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

Benefit Payment for Outpatient Treatment of Mental Illness and Outpatient Substance Abuse Rehabilitation Treatment

After you have met your Deductible, benefits for Outpatient treatment of Mental Illness will be provided at 50% of the Eligible Charge or at 50% of the Maximum Allowance when you receive Covered Services In-Network or Out-of-Network.

After you have met your Deductible, benefits for Outpatient Substance Abuse Rehabilitation Treatment will be provided at 50% of the Eligible Charge or at 50% of the Maximum Allowance, when you receive Covered Services from an In-Network or Out-of-Network Substance Abuse Treatment Facility.

Benefit Maximum for Outpatient treatment of Mental Illness and Outpatient Substance Abuse Rehabilitation Treatment

Your benefits for Outpatient Mental Illness and Outpatient Substance Abuse Rehabilitation Treatment are limited to a combined maximum of thirty (30) Outpatient visits per calendar year.

Benefit Payment for Inpatient Treatment of Mental Illness and Inpatient Substance Abuse Rehabilitation Treatment

- for Inpatient treatment of Mental Illness and Inpatient Substance Abuse Rehabilitation Treatment, in a Blue Cross and Blue Shield approved program In-Network, benefits will be provided at 60% of the Eligible Charge for the first 14 days of each admission after you have met your Deductible; thereafter, any remaining eligible Hospital charges will be paid at 50% of the Eligible Charge.
- for Inpatient treatment of Mental Illness and Inpatient Substance Abuse Rehabilitation Treatment, in a Blue Cross and Blue Shield approved program Out-of-Network, benefits will be provided at 50% of the Eligible Charge, after you have met your Deductible and the Inpatient Hospital admission Deductible.
- for Covered Services rendered by Professional Providers for the Inpatient treatment of Mental Illness or Inpatient Substance Abuse Rehabilitation Treatment, benefits will be provided at the Physician payment level shown on the Schedule Page after you have met your Deductible.

Benefit Maximum for Inpatient treatment of Mental Illness and Inpatient Substance Abuse Rehabilitation Treatment

Benefits for Inpatient treatment of Mental Illness and Inpatient Substance Abuse Rehabilitation Treatment are limited to a combined maximum of thirty (30) Inpatient Hospital days per calendar year.

COMPLICATIONS OF PREGNANCY

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

MASTECTOMY-RELATED SERVICES

Benefits for Covered Services related to mastectomies, including, but not limited to, 1) reconstruction of the breast on which the mastectomy has been performed; 2) surgery and reconstruction of the other breast to produce a symmetrical appearance; 3) post mastectomy care for inpatient treatment for a length of time determined by the attending Physician to be medically necessary and in accordance with protocols and guidelines based on sound scientific evidence and patient evaluation and a follow-up Physician office visit or in-home nurse visit within forty-eight (48) hours after discharge; and 4) prostheses and physical complications of all stages of the mastectomy including, but not limited to, lymphedemas; are the same as for any other condition.

TEMPOROMANDIBULAR JOINT DYSFUNCTION AND RELATED DISORDERS

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

PROGRAM PAYMENT PROVISIONS

OUT-OF-POCKET EXPENSE LIMIT

There are separate out-of-pocket expense limits applicable to Covered Services received In-Network and Out-of-Network.

In-Network

If you have Individual Coverage and your out-of-pocket expenses during one calendar year (the amount remaining unpaid for Covered Services after benefits have been provided plus the Deductible) equal the amount shown on the Schedule Page, any additional eligible In-Network Claims (except for those charges specifically excluded below) that you may have during that calendar year will be paid at 100% of the Eligible Charge or Maximum Allowance.

If you have Family Coverage and your family's out-of-pocket expenses during one calendar year (the amount remaining unpaid for Covered Services after benefits have been provided plus the Deductible) equal the amount shown on the Schedule Page, then, for the rest of the calendar year, all other family members will have benefits for eligible In-Network Covered Services (except for those charges specifically excluded below) provided at 100% of the Eligible Charge or Maximum Allowance. Benefits under Family Coverage will not be provided at the 100% payment level until the entire family out-of-pocket expense limit has been met.

The following expenses cannot be used to satisfy the In-Network out-of-pocket expense limit and the Covered Services listed will not be paid at 100% when the limit has been satisfied:

- charges that exceed the Eligible Charge or Maximum Allowance.
- charges for services that are not Covered Services.
- Coinsurance resulting from Out-of-Network Covered Services.
- Coinsurance resulting from Covered Services rendered by Non-Plan Providers.
- Copayments for noncompliance with the provisions of the Medical Services Advisory Program and/or the Blue Cross and Blue Shield Mental Health Unit.

The out-of-pocket expense limit amount may be adjusted based on the cost-of-living adjustment determined under the Internal Revenue code and rounded to the nearest $50.

Out-of-Network

If you have Individual Coverage and your out-of-pocket expenses during one calendar year (the amount remaining unpaid for Covered Services after benefits have been provided plus the Deductible) equal the amount shown on the Schedule Page, any additional eligible Out-of-Network Claims (except for those charges specifically excluded below) that you may have during that calendar year will be paid at 100% of the Eligible Charge or Maximum Allowance.

If you have Family Coverage and your out-of-pocket expenses during one calendar year (the amount remaining unpaid for Covered Services after benefits have been provided plus the Deductible) equal the amount shown on the Schedule Page, any additional eligible Out-of-Network Claims (except for those charges specifically excluded below) that you may have during that calendar year will be paid at 100% of the Eligible Charge or Maximum Allowance. Benefits under Family Coverage will not be provided at the 100% payment level until the entire family out-of-pocket expense limit has been met.

The following expenses cannot be used to satisfy the Out-of-Network out-of-pocket expense limit and the Covered Services listed will not be paid at 100% when the limit has been satisfied:

- charges that exceed the Eligible Charge or Maximum Allowance.
- charges for services that are not Covered Services.
- Coinsurance resulting from In-Network Covered Services.

- Copayments for noncompliance with the provisions of the Medical Services Advisory Program and/or the Blue Cross and Blue Shield Mental Health Unit.

The out-of-pocket expense limit amount may be adjusted based on the cost-of-living adjustment determined under the Internal Revenue code and rounded to the nearest $50.

EXCLUSIONS—WHAT IS NOT COVERED

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

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

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

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

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

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

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

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

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

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

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

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

— Services or supplies for any illness or injury arising out of or in the course of employment for which benefits are available under any Workers' Compensation Law or other similar laws whether or not you make a claim for such compensation or receive such benefits. However, this exclusion shall not apply if you are a corporate officer of any 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.

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

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

— Services or supplies that do not meet accepted standards of medical and/or dental practice.

— 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).

— Custodial Care Service.

— Long Term Care Service.

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

— Inpatient Private Duty Nursing.

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

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

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

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

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

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

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

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

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

— Immunizations, unless otherwise stated in this Policy.

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

— Maintenance Care.

— 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 this Policy for Autism Spectrum Disorder(s).

— 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 specified in this Policy.

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

— Wigs (also referred to as cranial prostheses).

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

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

— Maternity Service, including related services and supplies.

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

HOW TO FILE A CLAIM

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

Once Blue Cross and Blue Shield receives your Claim, it will be processed. The benefit payment for eligible Claims 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. Upon written request to Blue Cross and Blue Shield, you will be provided with the forms necessary for filing Claims under this Policy. Such forms should be furnished to you within fifteen (15) days of the request.
2. Attach copies of all bills to be considered for benefits. These bills must include the Provider's name and address, the patient's name, the diagnosis, the date of service and a description of the service and the Claim Charge.
3. Mail the completed Claim Form with attachments to:

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

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

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

TIME OF PAYMENT OF CLAIMS

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

CLAIM REVIEW PROCEDURES

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

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

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.

INTERNAL AND EXTERNAL REVIEW INFORMATION AND PROCEDURES

INQUIRIES AND COMPLAINTS

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

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

Blue Cross and Blue Shield has a team of professionals available to assist you with inquiries and complaints. Issues may include, but are not limited to, the following:

- Claims
- Quality of Care

You may contact **Customer Service** at the telephone number on the back of your identification card, or you may write to:

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

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

APPEALS

If you submit an inquiry or complaint and it is not resolved to your satisfaction, you may appeal the decision.

An appeal is an oral or written request for a review of an adverse decision or action by Blue Cross and Blue Shield or its employees. An appeal may be filed by you, a person designated to act on your behalf, or any health care provider.

No person reviewing the appeal may have been involved in the initial determination that is the subject of the appeal.

If an appeal is not resolved to your satisfaction, you may appeal Blue Cross and Blue Shield's decision to the Illinois Department of Insurance. The Illinois Department of Insurancewill notify Blue Cross and Blue Shield of the appeal. Blue Cross and Blue Shield will have 21 days to respond to the Illinois Department of Insurance.

URGENT/EXPEDITED CLINICAL APPEALS

An urgent/expedited clinical appeal is an appeal of a clinically urgent nature that relates to health care services, including, but not limited to, procedures or treatment ordered by a health care provider that, if a decision is denied, may significantly increase the risk to your health.

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

CLINICAL APPEALS

A clinical appeal is an appeal related to health care services, including, but not limited to, procedures or treatments ordered by a health care provider that does not meet the definition of an urgent/expedited clinical appeal.

Upon receipt of a non-urgent pre-service or post-service clinical appeal, Blue Cross and Blue Shield will notify the party filing the appeal within three business days if additional information is needed to review the appeal. Additional information must be submitted within five calendar days of the request. Blue Cross and Blue Shield will render a determination on the appeal within 15 business days after it receives the requested information, but in no event more than 30 days after the appeal has been received by Blue Cross and Blue Shield.

NOTIFICATION

Blue Cross and Blue Shield will notify the party filing the appeal, you, and any health care provider who recommended the services involved in the appeal, orally of its determination followed by a written notice of the determination.

The written notification will include:

- A clear and detailed reason for the determination.
- Medical or clinical criteria used in the determination.
- Procedures for requesting an external independent review, if your appeal is denied.

INDEPENDENT EXTERNAL REVIEW

An **"Adverse Determination"** means a determination by Blue Cross and Blue Shield or its designated utilization review organization that an admission, availability of care, continued stay, or other health care service that is a covered benefit has been reviewed and, based upon the information provided, does not meet Blue Cross and Blue Shield's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness and the requested service or payment for the service is therefore denied, reduced or terminated.

A **"Final Adverse Determination"** means an adverse determination involving a covered benefit that has been upheld by Blue Cross and Blue Shield or its designated utilization review organization, at the completion of Blue Cross and Blue Shield's internal grievance process procedures as set forth by the Managed Care Reform and Patient Rights Act.

EXPEDITED INDEPENDENT EXTERNAL REVIEW

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

You may also request an expedited external review if the treatment or service in question has been denied on the basis that it is considered experimental or investigational and your health care provider certifies in writing that the treatment or service would be significantly less effective if not started promptly.

Your request for an expedited independent external review may be submitted orally or in writing. Upon receipt of your request, an independent review organization registered with the Illinois Department of Insurance will be assigned to review Blue Cross and Blue Shield's decision.

Within two business days after the date of receipt of all necessary information, the expedited independent external reviewer will render a decision whether or not to uphold or reverse the Adverse Determination or Final Adverse Determination and you will receive notification from Blue Cross and Blue Shield. The decision of the external independent reviewer is final. Until July 1, 2013, if you disagree with the determination of the external independent reviewer, you may contact the Illinois Department of Insurance.

STANDARD EXTERNAL INDEPENDENT REVIEW

You must submit a written request for an external independent review within four months of receiving an Adverse Determination or Final Adverse Determination of a clinical appeal. You may submit additional information or documentation to support your request for the health care services.

Within five business days of receipt of your request, Blue Cross and Blue Shield will complete a preliminary review to determine whether:

- you or your dependent was a covered person at the time health care services were requested or provided;
- the service that is the subject of the Adverse Determination or the Final Adverse Determination was a Covered Service under this Policy but Blue Cross and Blue Shield has determined that the health care service does not meet Blue Cross and Blue Shield's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness;
- you have exhausted Blue Cross and Blue Shield's internal grievance process; and
- you have provided all the information and forms required to process an external review.

For appeals relating to a determination based on treatment being experimental or investigational, Blue Cross and Blue Shield will complete a preliminary review to determine whether the requested service or treatment that is the subject of the Adverse Determination or Final Adverse Determination is a Covered Service under this Policy, except for Blue Cross and Blue Shield 's determination that the service or treatment is experimental or investigational for a particular medical condition and is not explicitly listed as an excluded benefit under this Policy. In addition, the licensed Physician who ordered or provided the services in question has certified that one of the following situations is applicable:

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

Within one business day after completion of the preliminary review, Blue Cross and Blue Shield will notify you or your designated representative in writing whether the request is complete and is eligible for an external review. If the request is not complete or not eligible for an external review, you will be notified by Blue Cross and Blue Shield in writing of what materials are required or the reason for ineligibility.

Within five business days of determining that a request is eligible for an external review, Blue Cross and Blue Shield will a) assign an independent review organization from the list of approved independent review organizations; and b) notify you or your designated representative of the request's eligibility and acceptance for an external review and the name of the independent review organization.

Within five business days upon the assignment of an external independent review organization, Blue Cross and Blue Shield or it's designated utilization review organization, will provide to the external independent reviewer the documents and any information considered in making the Adverse Determination or Final Adverse Determination.

Within five business days after the date of receipt of the necessary information, the external independent reviewer will render a decision based on whether or not to uphold or reverse the Adverse Determination or Final Adverse Determination and you will receive notification from Blue Cross and Blue Shield. The decision of the external independent reviewer is final. Until July 1, 2013, if you disagree with the determination of the external independent reviewer, you may appeal the decision of the external independent review organization to the Illinois Department of Insurance at 877-527-9431.

Benefits will not be provided for services or supplies not covered under your Policy even if the external independent reviewer determines that the health care services being appealed were medically appropriate.

NON-CLINICAL APPEALS

A non-clinical appeal is an appeal of non-clinical issues, such as appeals pertaining to benefits and administrative procedures.

Upon receipt of a pre-service or post-service non-clinical appeal, Blue Cross and Blue Shield will notify the party filing the appeal within three business days if additional information is needed to review the appeal. Additional information must be submitted within five calendar days of the request. Blue Cross and Blue Shield will render a decision on the appeal within 15 business days after it receives the requested information.

NOTIFICATION

Blue Cross and Blue Shield will notify you and the party filing the non-clinical appeal orally of its determination, followed by a written notice of determination.

The written notification will include:

- A clear and detailed reason for the determination.
- Contractual, administrative or protocol for the determination.

Filing an appeal does not prevent you from filing a complaint with the Illinois Department of Insurance or keep the Illinois Department of Insurance from investigating a complaint. The Illinois Department of Insurance can be contacted at the following addresses:

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

or

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

In addition, if you have an adverse appeal determination, you may file civil action in a state or federal court.

GENERAL PROVISIONS

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

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

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

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

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

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

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

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

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

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

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

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

Blue Card

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

When you receive health care services through BlueCard outside of Illinois and from a Provider which does not have a contract with Blue Cross and Blue Shield, the amount you pay for Covered Services is calculated on the lower of:

- The billed charges for your Covered Services, or
- The negotiated price that the Host Blue passes on to Blue Cross and Blue Shield.

To help you understand how this calculation would work, please consider the following example:

a. Suppose you receive covered medical services for an illness while you are on vacation outside of Illinois. You show your identification card to the provider to let him or her know that you are covered by Blue Cross and Blue Shield of Illinois.

b. The provider has negotiated with the Host Blue a price of $80, even though the provider's standard charge for this service is $100. In this example, the provider bills the Host Blue $100.

c. The Host Blue, in turn, forwards the claim to Blue Cross and Blue Shield of Illinois and indicates that the negotiated price for the covered service is $80. Blue Cross and Blue Shield of Illinois would then base the amount you must pay for the service – the amount applied to your deductible, if any, and your coinsurance percentage – on the $80 negotiated price, not the $100 billed charge.

d. So, for example, if your coinsurance is 20%, you would pay $16 (20% of $80), not $20 (20% of $100). You are not responsible for amounts over the negotiated price for a covered service.

PLEASE NOTE: The coinsurance percentage in the above example is for illustration purposes only. The example assumes that you have met your deductible and that there are no copayments associated with the service rendered. Your Deductible(s), Coinsurance and Copayment(s) are specified in this Policy.

Often, this "negotiated price" will consist of a simple discount which reflects the actual price paid by the Host Blue. Sometimes, however, it is an estimated price that factors into the actual price increases or reductions to reflect aggregate payment from expected settlements, withholds, any other contingent payment arrangements and non-claims transactions with your health care provider or with a specified group of providers. The negotiated price may also be billed charges reduced to reflect an average expected savings with your health care provider or with a specified group of providers. The price that reflects average savings may result in greater variation (more or less) from the actual price paid than will the estimated price. The negotiated price will also be adjusted in the future to correct for over- or underestimation of past prices. However, the amount you pay is considered a final price.

Statutes in a small number of states may require the Host Blue to use a basis for calculating your liability for Covered Services that does not reflect the entire savings realized, or expected to be realized, on a particular claim or to add a surcharge. Should any state statutes mandate your liability calculation methods that differ from the usual BlueCard method noted above or require a surcharge, Blue Cross and Blue Shield would then calculate your liability for any covered health care services in accordance with the applicable state statute in effect at the time you received your care.

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

Blue Cross and Blue Shield hereby informs you that it has contracts, either directly or indirectly, with Prescription Drug Providers ("Participating Prescription Drug Providers") to provide prescription drug services to all persons entitled to prescription drug benefits under health policies and contracts to which Blue Cross and Blue Shield is a party, including all persons covered under this Policy. Under its contracts with Participating Prescription Drug Providers, Blue Cross and Blue Shield may receive from these Providers discounts for prescription drugs dispensed to you.

Blue Cross and Blue Shield owns a significant portion of the equity of Prime Therapeutics LLC and informs you that Blue Cross and Blue Shield has entered into one or more agreements with Prime Therapeu-

tics LLC or other entities (collectively referred to as "Pharmacy Benefit Managers") to provide, on Blue Cross and Blue Shield's behalf, Claim Payments and certain administrative services for your prescription drug benefits. Pharmacy Benefit Managers have agreements with pharmaceutical manufacturers to receive rebates for using their products. The Pharmacy Benefit Manager may share a portion of those rebates with Blue Cross and Blue Shield. You are not entitled to receive any portion of such rebates as they are figured into the pricing of the product.

2. PAYMENT OF CLAIMS AND ASSIGNMENT OF BENEFITS

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

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

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

3. YOUR PROVIDER RELATIONSHIPS

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

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

c. The use of an adjective such as Plan or In-Network 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, In-Network or any similar modifier or the use of a term such as Non-Plan or Out-of-Network should not be construed as carrying any statement or inference, negative or positive, as to the skill or quality of such Provider.

4. ENTIRE POLICY; CHANGES

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

5. OTHER COVERAGE WITH BLUE CROSS AND BLUE SHIELD

Coverage effective at any one time on you under a like policy or policies in this company is limited to the one such policy elected by you, your beneficiary, or your estate, as the case may be, and Blue Cross and Blue Shield will return all premiums paid for all other such policies.

6. NOTICES

Any information or notice which you furnish to Blue Cross and Blue Shield under this Policy must be in writing and sent to Blue Cross and Blue Shield, Administrator: Hallmark Services Corp., P.O. Box 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.

7. INFORMATION AND RECORDS

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

8. 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.

9. DEATH OF THE INSURED-REFUND OF PREMIUMS

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

10. PHYSICAL EXAMINATIONS AND AUTOPSY

Blue Cross and Blue Shield, at it's own expense shall have the right and opportunity to examine your person when and as often as it may reasonably require during the pendency of a Claim hereunder and to make an autopsy in case of death where it is not forbidden by law.

11. TIME LIMIT ON CERTAIN DEFENSES

After two (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 two (2) year period.

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

12. APPLICABLE LAW

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

13. 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 provision of this Policy, but this Policy shall be construed as if such invalid, illegal or unenforceable provision had never been contained herein.

14. SERVICE MARK REGULATION

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

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

REIMBURSEMENT PROVISION

If you or one of your covered dependents (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 the covered person, the covered person's parents, if the covered person is a minor, or the covered person's 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.

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

RIDER TO THE POLICY REGARDING PREVENTIVE CARE

(Applicable to policies DB–50 HCSC Rev. 5/06 & DB–51 HCSC)

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

The following **Well Child Care** Provision is added to your Policy hereby amending any previous Well Child Care under the Policy in its entirety to read as follows:

Well Child Care

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

- immunizations;
- physical examinations;
- routine diagnostic tests.
  - — When you receive Covered Services for well child care from a Participating Professional Provider, benefits for Covered Services will be provided at 100% of the Maximum Allowance and are subject to a Copayment of $20. Your Deductible does not apply.
  - — When you receive Covered Services for well child care from a Non–Participating Provider, benefits for well child care will be provided at the Non–Participating Provider Physician payment level shown on the Schedule Page after you have met your Deductible.

Benefits for well child care are limited to a maximum of $500 per child, per calendar year, when you receive Covered Services from a Non-Participating Provider.

The following **WELLNESS CARE** Provision is added to your Policy hereby amending any previous Wellness Care under the Policy in its entirety to read as follows:

WELLNESS CARE

Benefits will be provided for Covered Services rendered to persons age 16 and over, even though you are not ill. Benefits will be limited to the following services:

(1) immunizations;

(2) routine physical examinations – one per calendar year;

(3) routine gynecological examinations – one per calendar year;

(4) routine diagnostic tests ordered or received on the same day as the examination.

- — When you receive Covered Services for wellness care in a Participating Professional Provider's office, benefits for Covered Services will be provided at 100% of the Maximum Allowance and are subject to a Copayment of $20 for Physician office visits. Your Deductible does not apply.
- — When you receive Covered Services for wellness care from a Participating Provider, other than in a Physician's office, benefits for wellness care will be provided at 100% of the Eligible Charge or 100% of the Maximum Allowance and will not be subject to a Deductible.
- — When you receive Covered Services for wellness care from a Non–Participating Provider, benefits for wellness care will be provided at the Non–Participating Provider Hospital or Physician payment level shown on the Schedule Page after you have met your Deductible.

Wellness care benefits will be limited to a maximum of $500 per calendar year. 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

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

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

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
President and CEO

Deborah Dorman-Rodriguez
Secretary

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)

Deborah Doman-Rodriguez

Secretary

Patricia A. Hemingway Hall

President

OMNIBUS RIDER TO THE POLICY

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

A. DEFINITIONS SECTION

1. The following definition of **Audiologist** is hereby added to the Definitions Section:

   AUDIOLOGIST.....means a duly licensed audiologist.

   A "Participating Audiologist" means an Audiologist who has a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

   A "Non-Participating Audiologist" means an Audiologist who 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 services to you at the time services are rendered.

B. PHYSICIAN BENEFIT SECTION

1. The following is added to the list of **Participating Professional Providers**:

   Audiologists

2. The following is added to the list of **Non-Participating Professional Providers**:

   Audiologists

C. OTHER COVERED SERVICES

1. The following is added to the list of **Participating Professional Providers**:

   Audiologists

2. The following is added to the list of **Non-Participating Professional Providers**:

   Audiologists

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*e*

Patricia A. Hemingway Hall

Patricia A. Hemingway Hall
President and CEO

Deborah Dorman-Rodriguez

Deborah Dorman-Rodriguez
Secretary

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 definitions for Eligible Charge and Maximum Allowance are deleted and replaced with the following:

ELIGIBLE CHARGE.....means (a) in the case of a Provider, other than a Professional 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, other than a Professional 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.

MAXIMUM ALLOWANCE.....means (a) the amount which Participating Professional Providers have agreed to accept as payment in full for a particular Covered Service. All benefit payments for Covered Services rendered by Participating Professional Providers will be based on the Schedule of Maximum Allowances which these Providers have agreed to accept as payment in full. Benefit payments for Covered Services rendered by Participating Professional Providers for the treatment of Mental Illness and/or Substance Abuse Rehabilitation Treatment will be based on the Schedule

of Maximum Allowances applicable to Managed Care Mental Health and Substance Abuse Rehabilitation Treatment benefits which these Providers have agreed to accept as payment in full. (b) For Non-Participating Professional Providers, the Maximum Allowance will be the lesser of:

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

(ii) the Blue Cross and Blue Shield of Illinois non-contracting Maximum Allowance. Except as otherwise provided in this section, the non-contracting Maximum Allowance is developed from base Medicare reimbursements and represents approximately 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 Maximum Allowance for Coordinated Home Care Program Covered Services will be 50% of the Non-Participating Professional Provider's standard billed charge for such Covered Services.

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

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

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

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

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

RIDER TO THE POLICY

Effective Date: 10/01/2010

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

EXCLUSIONS—WHAT IS NOT COVERED

The hearing aid exclusion is revised to read as follows:

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

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

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

Jeffrey R. Tikkanen
President, Retail Markets

RIDER TO THE POLICY 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

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).

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 **Out-of-Network** payment level under **BENEFIT PAYMENT FOR PHYSICIAN SERVICES**:

When you receive Covered Services, from an In-Network 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 an In-Network Provider and Covered Services are provided by an Out-of-Network Provider, you will incur no greater out-of-pocket costs than you would have incurred if the Covered Services were provided by an In-Network Provider.

However, in the event that you willfully choose to receive Covered Services from an Out-of-Network Provider when an In-Network Professional Provider is available, or you or the Out-of-Network 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.

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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

NOTICE TO APPLICANT REGARDING REPLACEMENT OF HEALTH INSURANCE

According to information you have furnished, you intend to lapse or otherwise terminate existing health insurance and replace it with a policy to be used by Health Care Service Corporation. For your own information and protection, you should be aware of and seriously consider factors which may affect the insurance protection available to you under the new policy.

1. Health conditions which you may presently have, which may be referred to in the policy as pre-existing conditions, may not be immediately or fully covered under this new policy. This could result in denial or delay of a claim for benefits under this new policy, whereas a similar claim might have been payable under your present policy.

2. You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.

3. If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical/health history. FAILURE TO INCLUDE ALL MATERIAL MEDICAL INFORMATION ON AN APPLICATION MAY PROVIDE A BASIS FOR THE COMPANY TO DENY CLAIMS AND TO REFUND YOUR PREMIUM AS THOUGH YOUR POLICY HAS NEVER BEEN IN FORCE. After the application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded.

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CONSUMER MARKETS

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

BlueCross BlueShield of Illinois

YOUR INFORMATION. YOUR RIGHTS. OUR RESPONSIBILITIES.

This notice describes how Blue Cross and Blue Shield of Illinois can use or disclose your medical information and how you can get access to this information. Our contact information can be found at the end of the notice. **Please review this notice carefully.**

YOUR RIGHTS. When it comes to your health information, you have certain rights.

This section explains your rights and some of our responsibilities to help you.

Get a copy of your health and claims records	* You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this by using the contact information at the end of this notice. * We will provide a copy or a summary of your health and claims records usually within 30 days of the request. We may charge a reasonable, cost-based fee.
Ask us to correct health and claims records	* You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this by using the contact information at the end of this notice. * We may say "no" to your request. We'll tell you why in writing within 60 days.
Request confidential communications	* You can ask us to contact you in a specific way or to send mail to a different address Ask us how to do this by using the contact information at the end of this notice. * We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.
Ask us to limit what we use or share	* You can ask us **not** to share or use certain health information for treatment, payment or our operations. Ask how to do this by using the contact information at the end of this notice. * We are not required to agree to your request, and we may say "no" if it would affect your care.
Get a list of those with whom we've shared information	* You can ask for a list (accounting) for six years prior to your request date of when we shared your information, who we shared it with and why. Ask us how to do this by using the contact information at the end of this notice. * We will include all the disclosures except for those about treatment, payment, and our operations, and certain other disclosures (such as any you asked us to make). We will provide one accounting a year for free but we may charge a reasonable, cost-based fee if you ask for another one within 12 months.
Get a copy of this notice	* You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. To request a copy of this notice, use the contact information at the end of this notice and we will send you one promptly.
Choose someone to act for you	* If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. Ask us how to do this by using the contact information at the end of this notice. * We confirm the person has the authority and can act for you before we share your information.

BlueCross BlueShield of Illinois

YOUR RIGHTS (continued)

File a complaint if you feel your rights are violated	* You can complain if you feel we have violated your privacy rights by using the contact information at the end of this notice. * You can also file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by calling 1-877-696-6775; or by visiting www.hhs.gov/ocr/privacy/hipaa/complaints/ or by sending a letter to them at: 200 Independence Ave., SW, Washington, D.C. 20201. * We will not retaliate against you for filing a complaint.

YOUR CHOICES. For certain health information, you can tell us your choices about what we share.

If you have a clear preference on how you want us to share your information in the situations described below, tell us and we will follow your instructions. Use the contact information at the end of this notice.

In these cases, you have both the right and choice to tell us to:	* Share information with your family, close friends, or others involved in payment for your care * Share information in a disaster or relief situation * Contact you for fundraising efforts

If you cannot share your preference, for example, if you are unconscious, we can share your information if we think it is in your best interest. We may share information when needed to lessen a serious or imminent threat to health or safety.

We *never share your* information in these situations unless you give us written permission	* Marketing purposes * Sale of your information

OUR USES AND DISCLOSURES. How do we use or share your health information?

We typically use or share your health information in the following ways.

Help manage the health care treatment you receive	* We can use your health information and share it with professionals who are are treating you.	* *Example: A doctor sends us information about our diagnosis and treatment plan so we can arrange additional services.*
Run our organization	* We can use and disclose your information to run our organization and contact you when necessary.	* *Example: We use health information to develop better services for you.*

We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. *This does not apply to long-term care plans.*

Pay for your health services	* We can use and disclose your health information since we pay for your health services.	* *Example: We share information about you with your dental plan to coordinate payment for your dental work.*

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Administer your plan	* We may disclose your health information to your health plan sponsor for plan administration purposes.	**Example: If your company contracts with us to provide a health plan, we may provide them certain statistics to explain the premiums we charge.*

How else can we use or share your health information?

We are allowed or required to share your information in other ways, usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information go to: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.**

Help with public health and safety issues	* We can share your health information for certain situations such as: * Preventing disease * Helping with product recalls * Reporting adverse reactions to medications * Reporting suspected abuse, neglect or domestic violence * Preventing or reducing a serious threat to anyone's health or safety
Do research	* We can use or share your information for health research.
Comply with the law	* We will share information about you when state or federal law requires it, including the Department of Health and Human Services if they want to determine that we are complying with federal privacy laws.
Respond to organ/tissue donation requests and work with certain professionals	* We can share health information about you with an organ procurement organization. * We can share information with a medical examiner, coroner or funeral director.
Address workers' compensation, law enforcement, and other government requests	* We can use or share health information about you: * For workers' compensation claims * For law enforcement purposes or with a law enforcement official * With health oversight agencies for activities authorized by law * For special government functions such as military, national security, and presidential protective services or with prisons regarding inmates.
Respond to lawsuits and legal actions	* We can share health information about you in response to an administrative or court order, or in response to a subpoena.
Certain health information	* State law may provide additional protection on some specific medical conditions or health information. For example, these laws may prohibit us from disclosing or using information related to HIV/AIDS, mental health, alcohol or substance abuse and genetic information without your authorization. In these situations, we will follow the requirements of the state law.

BlueCross BlueShield of Illinois

OUR RESPONSIBILITIES. When it comes to your information, we have certain responsibilities.

* We are required by law to maintain the privacy and security of your protected health information.
* We will let you know promptly if a breach occurs that compromises the privacy or security of your information.
* We must follow the duties and privacy practices described in this notice and give you a copy of it.
* We will not use or share your information other than as described here unless you tell us we can in writing.

You may change your mind at any time. Let us know in writing if you change your mind.

For more information: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.**

CHANGES TO THE TERMS OF THIS NOTICE

We can change the terms of this notice, and the changes we make will apply to all information we have about you. The new notice will be available upon request or from our website. We will also mail a copy of the new notice to you if there are material changes to our privacy practices.

CONTACT INFORMATION

If you would like general information about your privacy rights or would like a copy of this notice, go to: http://www.bcbsil.com/important_info/index.html. If you have specific questions about your rights or about this notice, you may contact us in one of the following ways:

* Call us at the toll-free number on the back of your member identification card.
* Call us at 1-877-361-7594.
* Write us at:

Divisional Vice President, Privacy Office
Blue Cross and Blue Shield of Illinois
P.O. Box 804836
Chicago, IL 60680-4110

EFFECTIVE DATE OF THIS NOTICE

September 23, 2013