
BASIC HOSPITAL AND MEDICAL/SURGICAL EXPENSE POLICY



**BlueCross BlueShield
of Illinois**

An Independent Licensee of the
Blue Cross and Blue Shield Association

Health Care Service Corporation, a Mutual Legal Reserve Company

RIGHT TO EXAMINE THIS POLICY

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

CONDITIONAL RENEWABILITY

Coverage under this Policy will be terminated for persons who become eligible for Medicare, for ineligible dependents and for non-payment of premium. Blue Cross and Blue Shield can refuse to renew this Policy only for the following reasons:

1. If every Policy bearing this Policy form number, DB-26 HCSC, is not renewed;
2. In the event of fraud or material misrepresentation in filing a claim for benefits under this Policy;
3. If you have Other Coverage in force which provides benefits reasonably similar to those provided under this Policy.

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

If Blue Cross and Blue Shield refuses to renew this Policy for any of the reasons stated above, we will give you at least 30 days prior written notice.

NOTICE OF ANNUAL MEETING

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

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.

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.

TABLE OF CONTENTS

Benefit Highlights	1
Eligibility and Premium Information	3
Waiting Period and Program Payment Provisions	6
Medical Services Advisory Program (MSA)	9
Hospital Benefits	12
Hospice Care Program	15
Physician Benefits	16
Other Covered Services	18
Special Conditions	19
Exclusions-What Is Not Covered	20
How to File a Claim	23
General Provisions	25
Reimbursement Provision	28
Definitions	29
Index	35

BENEFIT HIGHLIGHTS

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

LIFETIME BENEFIT MAXIMUM \$5,000,000

DEDUCTIBLES

Individual Deductible
and Family Deductible Deductible amounts are specified
on the **Schedule Page**

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

OUT-OF-POCKET EXPENSE LIMITS

Individual and Family
Out-of-Pocket Expense Limits out-of-pocket expense limits are specified
on the **Schedule Page**

THE MEDICAL SERVICES ADVISORY PROGRAM

MSA®

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

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

BENEFIT PAYMENT LEVELS

Hospital Benefits

- In a **PPO Hospital** **80% of the Eligible Charge**
- In a **Non-PPO Hospital** **60% of the Eligible Charge**
- In a **Non-Plan Hospital** **50% of the Eligible Charge**

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

Emergency Care

Emergency Accident Care – Hospital and Physician **80% of the Eligible Charge
or Usual and Customary Fee,
no Deductible**

Emergency Medical Care – Hospital and Physician **80% of the Eligible Charge
or Usual and Customary Fee,
no Deductible**
(Inpatient admission required within
72 hours of Emergency Medical Care,
except for Covered Services received
resulting from sexual assault or abuse)

ELIGIBILITY AND PREMIUM INFORMATION

APPLICATION FOR COVERAGE

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

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.

SCHEDULE PAGE

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

INDIVIDUAL COVERAGE

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

FAMILY COVERAGE

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

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

Any children who are dependent upon you for support and maintenance because of mental retardation or physical handicap will be covered regardless of age if they were covered prior to reaching the limiting age stated above.

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

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

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

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

CHANGING FROM FAMILY COVERAGE 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 ELIGIBILITY CHANGES

— Medicare Eligibility

Coverage for any person covered under this Policy who becomes eligible for Medicare will automatically terminate on the first day of the month in which such person reaches age 65 or otherwise becomes eligible for Medicare. Blue Cross and Blue Shield will, at that time, offer such person a new Policy of the type generally offered to persons in that age or eligibility classification. The premium for the new Policy must be paid within 30 days of the termination of this Policy.

— 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, a new Policy of the same type. Application for such Policy must be made within 60 days of the date of the divorce decree. 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 under the new Policy(s) will be considered as being met to the extent that such waiting period was satisfied under this Policy.

— Death of the Insured

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. If your spouse chooses Individual Coverage and there are also dependent children covered under this Policy, those dependent children are entitled to have separate Individual Coverage Policies issued to each of them without Evidence of Insurability. Application for such Policies must be made within 60 days of the date of death or of the date that your spouse applies for Individual Coverage. Any Preexisting Conditions waiting period under the new Policy(s) will 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 or marrying), he or she may convert to a separate "Conversion Policy" on an Individual Coverage basis. He or she may not convert to a Conversion Policy providing Family Coverage. Evidence of Insurability will not be required and any Preexisting Conditions waiting period applicable to the Conversion Policy will be

considered as being met to the extent that such waiting period was satisfied under this Policy. If the former dependent child elects to apply for an Individual Coverage Policy other than the Conversion Policy, Evidence of Insurability will be required.

PAYMENT OF PREMIUM

Your first premium payment is due on your Coverage Date. Later premiums are due and payable on the due date, which is dependent upon the premium mode you selected. The premium mode you selected is shown on the Schedule Page of this Policy.

The initial premium for Individual Coverage is based upon your age at the time your coverage commences. The initial premium for Family Coverage is based upon your age, your spouse's age and the dependent children that are covered at the time that Family Coverage commences.

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:

- 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;
- 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;
- whenever anyone who is covered under this Policy attains an age which results in a change in the premium amount due for that age category of coverage;
- whenever the number of persons covered under this Policy is changed;
- whenever you move your residence from one geographical rating area to another.

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

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

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 provided by and regularly charged for by the Hospital, Skilled Nursing Facility or Coordinated Home Care Program until you are discharged or until you reach any applicable maximum benefit amount, whichever occurs first. No other benefits will be provided after your coverage under this Policy is terminated.

WAITING PERIOD AND PROGRAM PAYMENT PROVISIONS

Before reading the descriptions of your benefits in the sections of this Policy that follow, it is important that you fully understand the provisions stated below. Please refer to the DEFINITIONS Section of this Policy for additional information regarding these provisions. If a term is defined in the Definitions Section, it is capitalized when used in this Policy.

PREEXISTING CONDITIONS WAITING PERIOD

Your benefits are subject to a Preexisting Conditions waiting period of **365 days**. The Preexisting Conditions waiting period begins on your Coverage Date for you and your covered dependents if you have Family Coverage and continues for 365 days. This Preexisting Conditions waiting period will also apply to each dependent (other than a newborn child, if application for coverage is made within 31 days of birth) for whom coverage is applied after your Coverage Date. The Preexisting Conditions waiting period for such a dependent will begin on the dependent's Coverage Date. Until the Preexisting Conditions waiting period has ended, benefits will not be provided for a Preexisting Condition.

DEDUCTIBLES

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

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

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

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

The following Covered Services are not subject to the calendar year Deductible:

- EMERGENCY ACCIDENT CARE
- EMERGENCY MEDICAL CARE
- ADDITIONAL OPINION CONSULTATIONS

OUT-OF-POCKET EXPENSE LIMIT

Separate out-of-pocket expense limits are applicable to Covered Services received in PPO Hospitals and Non-PPO Hospitals. The amounts of these out-of-pocket expense limits are shown on the Schedule Page. There are no limits on out-of-pocket expenses for services received from Non-Plan Hospitals or Non-Plan facilities.

— For PPO Hospitals and Physician Covered Services

If, during one calendar year, your total out-of-pocket expenses (the amount remaining unpaid for Covered Services after benefits have been provided) equal the amount of the Individual Out-of-Pocket Expense Limit shown on the Schedule Page, any additional eligible Claims (except as excluded below) that you may have during that calendar year will be paid at 100% of the Eligible Charge or Usual and Customary Fee.

The following expenses are not considered eligible out-of-pocket expenses, that is, they cannot be used to satisfy the out-of-pocket expense limit and the Covered Services listed will not be paid at 100% when the limit has been satisfied:

- the calendar year Deductible;
- charges that exceed the Eligible Charge or Usual and Customary Fee;
- charges for services that are not Covered Services;
- coinsurance or Deductibles applicable to Covered Services rendered by Non-PPO Hospitals, Non-Plan Hospitals or Non-Plan facilities;
- Copayments resulting from noncompliance with the provisions of the MSA Program.

If you have **Family Coverage** and three or more members of your family have eligible out-of-pocket expenses (as described above) during one calendar year equal to the Family Out-of-Pocket Expense Limit shown on the Schedule Page, then, for the rest of that year, all other family members will have benefits for Covered Services provided at 100% of the Eligible Charge or Usual and Customary Fee.

— For Non-PPO Hospitals

If, during one calendar year, your out-of-pocket expenses for Covered Services rendered by Non-PPO Hospitals equal the amount of the Individual Out-of-Pocket Expense Limit shown on the Schedule Page, any additional eligible Claims for Covered Services rendered by a Non-PPO Hospital (except as excluded below) that you may have during that calendar year will be paid at 100% of the Eligible Charge.

The following expenses are not considered eligible out-of-pocket expenses, that is, they cannot be used to satisfy the out-of-pocket expense limit and the Covered Services listed will not be paid at 100% when the limit has been satisfied:

- the calendar year Deductible;
- the Inpatient Non-PPO/Non-Plan Hospital Deductible;
- charges that exceed the Eligible Charge or Usual and Customary Fee;
- charges for services that are not Covered Services;
- coinsurance applicable to Covered Services received from a PPO Hospital, a Non-Plan Hospital or a Plan or Non-Plan facility;
- coinsurance applicable to Covered Services received from a Physician or other professional Provider;
- Copayments resulting from noncompliance with the provisions of the MSA Program.

If you have **Family Coverage** and three or more members of your family have eligible out-of-pocket expenses for Covered Services received from Non-PPO Hospitals during one calendar year equal to the Family Out-of-Pocket Expense Limit shown on the Schedule Page, then, for the rest of that year, all other family members will have benefits for Covered Services rendered by a Non-PPO Hospital provided at 100% of the Eligible Charge or Usual and Customary Fee.

LIFETIME MAXIMUM

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

As you use your benefits, a certain amount will automatically be restored to your lifetime maximum each year. This amount will be \$1,000 or the amount you have received in benefits during that calendar year, whichever

is less. Also, your lifetime maximum will be restored in full if you furnish Evidence of Insurability which is satisfactory to Blue Cross and Blue Shield.

MEDICAL SERVICES ADVISORY PROGRAM (MSA)

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

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

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

PREADMISSION REVIEW

Inpatient Hospital Preadmission Review

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

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

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

Emergency Admission Review

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

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

CASE MANAGEMENT

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

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

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

LENGTH OF STAY/SERVICE REVIEW

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

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

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

MEDICALLY NECESSARY DETERMINATION

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

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

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

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

MSA PROCEDURE

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

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

When you contact the MSA, the MSA:

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

APPEAL PROCEDURE

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

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

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

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

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

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

FAILURE TO NOTIFY

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

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

HOSPITAL BENEFITS

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.

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

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

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. **This Policy does not provide any benefits for Substance Abuse Rehabilitation Treatment or the treatment of Mental Illness.**

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.
3. **Preadmission Testing**

Benefits will be 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.

— Inpatient Skilled Nursing Facility Care

Benefits will be provided for the same services that are available to you as an Inpatient in the Hospital. Benefits will not be provided for services received in an Uncertified Skilled Nursing Facility.

— Coordinated Home Care

Benefits will be provided for services received in a Plan Coordinated Home Care Program. Benefits will not be provided for services received in a Non-Plan Coordinated Home Care Program.

BENEFIT PAYMENT FOR INPATIENT COVERED SERVICES

PPO Provider	After you have met your calendar year Deductible , benefits will be provided at 80% of the Hospital's Eligible Charge when you receive Inpatient Covered Services in a PPO Hospital , in a Plan Coordinated Home Care Program of a PPO Hospital or in a Plan Skilled Nursing Facility .
Non-PPO Provider	When you receive Inpatient Covered Services in a Non-PPO Hospital or in a Plan Coordinated Home Care Program of a Non-PPO Hospital , benefits will be provided at 60% of the Eligible Charge, after you have met your calendar year Deductible and, for Non-PPO Hospital services, a separate \$300 Inpatient Non-PPO Hospital Deductible .
Non-Plan Provider	When you receive Inpatient Covered Services in a Non-Plan Hospital or in a Non-Plan Skilled Nursing Facility , benefits will be provided at 50% of the Eligible Charge after you have met your calendar year Deductible and, for Non-Plan Hospital services, a separate \$300 Inpatient Non-Plan Hospital Deductible .

Emergency Admissions

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

For that portion of your Inpatient Hospital stay during which your condition is reasonably determined by Blue Cross and Blue Shield not to be life threatening, benefits will be provided at 50% of the Eligible Charge for Covered Services if you are in a Non-Plan Hospital or at 60% of the Eligible Charge if you are in a Non-PPO Hospital.

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

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

1-800-852-5890

OUTPATIENT COVERED SERVICES

You are entitled to benefits for the following services when you receive these 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. Benefits will also be provided for preoperative tests given to you as an Outpatient to prepare you for Surgery except that benefits will not be provided for such tests if you cancel or postpone the Surgery.
2. **Radiation therapy treatments**
3. **Chemotherapy**
4. **Renal Dialysis Treatments** - these treatments are eligible for benefits if you receive them in a Hospital, in a Dialysis Facility or in your home under the supervision of a Hospital or Dialysis Facility.
5. **Emergency Accident Care** - treatment must occur within 72 hours of the accident.

6. **Emergency Medical Care** - benefits will be provided only if you are admitted to the Hospital as an Inpatient for the same illness within 72 hours of the Emergency Medical Care. However, you do not need to be admitted to the Hospital as an Inpatient for Covered Services received for Emergency Medical Care resulting from criminal sexual assault or abuse.
7. **Mammograms**

BENEFIT PAYMENT FOR OUTPATIENT COVERED SERVICES

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

- **80%** of the Eligible Charge for Outpatient Covered Services received in a PPO Hospital, Plan Ambulatory Surgical Facility or Plan Dialysis Facility.
- **60%** of the Eligible Charge when you receive Outpatient Covered Services in a Non-PPO Hospital.
- **50%** of the Eligible Charge for Outpatient Covered Services in a Non-Plan Hospital, Non-Plan Ambulatory Surgical Facility or Non-Plan Dialysis Facility.

Benefits for **Emergency Accident Care and Emergency Medical Care** will be provided at 80% of the Eligible Charge whether rendered in a PPO, Non-PPO or Non-Plan Hospital and are not subject to a Deductible.

WHEN SERVICES ARE NOT AVAILABLE IN A PPO HOSPITAL

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

HOSPICE CARE PROGRAM

Effective **July 1, 1996**, your Hospital coverage 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 not be eligible for Medicare and must have a life expectancy of 6 months or less, as certified by your attending Physician; and you will no longer benefit from standard medical care or have chosen to receive hospice care rather than standard care. Also, a family member or friend must be available to provide custodial type care between visits from Hospice Care Program Providers if hospice is being provided in the home.

The following services are covered under the Hospice Care Program:

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

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

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

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

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

PHYSICIAN BENEFITS

This section of your Policy explains 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 including 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. **This Policy does not provide any benefits for Substance Abuse Rehabilitation Treatment or the treatment of Mental Illness.**

For benefits to be available, the Covered 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 and for any related Diagnostic Services received on the same day as the Surgery. For services performed by a Dentist or Podiatrist, benefits are limited to those surgical procedures which may be legally rendered by them and which would be payable under this Policy had they been performed by a Physician. Benefits for oral Surgery are limited to the following services:

1. surgical removal of complete bony impacted teeth;
2. excision of tumors or cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth;
3. surgical procedures required 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 such 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 of, or excision of, the temporomandibular joints.

The following services are also part of your surgical benefits:

- **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.
- **An Assistant Surgeon** - Services by a Physician, Dentist or Podiatrist who assists the operating surgeon in performing covered Surgery, but only if a Hospital intern or resident is not available for such assistance.

— Medical Care

Benefits are available for Medical Care visits only when you are an Inpatient in a Hospital or Skilled Nursing Facility or you are a patient in a Coordinated Home Care Program. No benefits are available for Substance Abuse Treatment or treatment of Mental Illness.

— **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**

— **Radiation Therapy Treatments**

— **Chemotherapy**

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

— **Emergency Medical Care** - benefits will be provided only if you are admitted to the Hospital as an Inpatient for the same illness within 72 hours of the Emergency Medical Care. However, you do not need to be admitted to the Hospital as an Inpatient for Covered Services received for Emergency Medical Care resulting from criminal sexual assault or abuse.

BENEFIT PAYMENT FOR PHYSICIAN SERVICES

When you receive any of the Covered Services described in this Physician Benefits Section, 80% of the Usual and Customary Fee will be paid **after you have met your calendar year Deductible**. Benefits for Emergency Accident Care and Emergency Medical Care are not subject to a Deductible.

OTHER COVERED SERVICES

COVERED SERVICES

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

- **Ambulance Transportation** – when rendered in connection with a covered Inpatient admission or covered Emergency Accident Care or covered Emergency Medical Care. Benefits will not be provided for long distance trips.
- **Dental accident care** – dental services rendered by a Dentist or Physician which are required as the result of an accidental injury. However, these services are covered only if the injury occurred on or after your Coverage Date.
- **Prosthetic appliances** – Benefits will be provided for prosthetic devices, special appliances and surgical implants required by you for an illness or injury beginning on or after your Coverage Date when:
 - they are required to replace all or part of an organ or tissue of the human body; or
 - they are required to replace all or part of the function of a non-functioning or malfunctioning organ or tissue.

Benefits will be provided only for the initial prosthetic device, special appliance or surgical implant and not for any replacement, repair or adjustment.

BENEFIT PAYMENT FOR OTHER COVERED SERVICES

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

SPECIAL CONDITIONS

COMPLICATIONS OF PREGNANCY

Benefits will be provided under this Policy for Covered Services received in connection with Complications of Pregnancy. Benefits will not be provided under this Policy for Maternity Service.

HUMAN ORGAN TRANSPLANTS

Benefits for all of the Covered Services previously described in this Policy are available for human organ transplants. Benefits will be provided only for **cornea, kidney, bone marrow, heart valve, muscular-skeletal, parathyroid, heart, heart/lung, lung, liver, pancreas and pancreas/kidney** human organ or tissue transplants. In addition, benefits will be provided at 80% of the Eligible Charge for immunosuppressive drugs prescribed in connection with the Surgery.

Benefits are available for 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 his or her benefits paid by his or her 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.

Benefits for heart, heart/lung, lung, liver, pancreas and pancreas/kidney organ transplants will begin no earlier than five days prior to the transplant Surgery and will continue for a period of no longer than 365 days after the transplant Surgery. Benefits will include all Inpatient and Outpatient Covered Services related to the transplant Surgery.

Benefits will also be provided for transportation of the donor organ to the location of the transplant Surgery, limited to transportation of the donor organ within the United States and Canada.

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

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

1. Cardiac rehabilitation services when not begun immediately after discharge from the Hospital for the transplant Surgery;
2. Transportation by air ambulance for the donor or recipient;
3. Travel time and related expenses required by a Provider;
4. Drugs which are Investigational.

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 judgment 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 their continued stay in a Hospital.
- Hospitalization or admission to a Skilled Nursing Facility, nursing home or other facility for the primary purposes of providing Custodial Care 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 this appeal as a precondition to the taking of any further action against Blue Cross and Blue Shield, either at law or in equity. To initiate your appeal, you must give Blue Cross and Blue Shield written notice of your intention to do so within 60 days after you have been notified that your Claim has been denied by writing to:

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

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

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

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

- Services or supplies for any illness or injury arising out of or in the course of employment for which benefits are available under any Workers' Compensation Law or other similar laws whether or not you make a claim for such compensation or receive such benefits. However, this exclusion shall not apply if you are a corporate officer of any business or enterprise, defined as a "small business" under paragraph (b), Section 3 of the Illinois Small Business Purchasing Act, as amended, and are employed by the corporation and elect to withdraw yourself from the operation of the Illinois Workers' Compensation Act according to the provisions of the Act.
- Services or supplies that are furnished to you by the local, state or federal government and for any services or supplies to the extent payment or benefits are provided or available from the local, state or federal government (for example, Medicare) whether or not that payment or benefits are received, except however, this exclusion shall not be applicable to medical assistance benefits under Article V, VI or VII of the Illinois Public Aid Code (Ill. Rev. Stat. ch. 23 § 1-1 et seq.) or similar Legislation of any state, benefits provided in compliance with the Tax Equity and Fiscal Responsibility Act or as otherwise provided by law.
- Services or 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.
- Custodial Care Service.
- Outpatient Medical Care including, but not limited to, routine physical examinations.
- Immunizations.
- Outpatient Diagnostic Service except when rendered on the same day as and in connection with Surgery or as part of covered Emergency Accident Care or Emergency Medical Care or additional surgical/medical opinions required by the MSA.
- Emergency Medical Care unless such care is followed by Inpatient admission to a Hospital within 72 hours of the care, unless otherwise specified in this Policy.
- Outpatient drugs or medicines except for immunosuppressive drugs prescribed in connection with a human organ transplant.
- Services or supplies rendered for Substance Abuse Rehabilitation Treatment or for the treatment of Mental Illness.
- 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.
- Cosmetic Surgery and related services and supplies, except for the correction of congenital deformities or for conditions resulting from accidental injuries, tumors or diseases.

- Services or supplies received from a dental or medical department or clinic maintained by an employer, labor union or other similar person or group.
- Services or supplies for which you are not required to make payment or would have no legal obligation to pay if you did not have this or similar coverage.
- Charges for failure to keep a scheduled visit or charges for completion of a Claim form.
- Personal hygiene, comfort or convenience items commonly used for other than medical purposes such as air conditioners, humidifiers, physical fitness equipment, televisions and telephones.
- Medical equipment or special braces, splints, specialized equipment, appliances, ambulatory apparatus, or battery or atomically controlled implants, except as specifically mentioned in this Policy.
- Procurement or use of prosthetic devices, special appliances or surgical implants which are for cosmetic purposes, the comfort and convenience of the patient, or unrelated to the treatment of a disease or injury.
- Replacement or repair of or adjustments to prosthetic devices, special appliances or surgical implants.
- Blood derivatives which are not classified as drugs in the official formularies.
- Private Duty Nursing Service.
- Eyeglasses, contact lenses or cataract lenses and the examination for prescribing or fitting of glasses or contact lenses or for determining the refractive state of the eye.
- Hearing aids or examinations for the prescription or fitting of hearing aids.
- Services and supplies rendered in connection with Temporomandibular Joint Dysfunction and Related Disorders except as otherwise specifically mentioned in this Policy.
- Treatment of flat foot conditions and the prescription of supportive devices for such conditions, treatment of subluxations of the foot, routine foot care or corrective shoes.
- Outpatient Occupational, Physical or Speech Therapy.
- Services and supplies rendered or provided for human organ or tissue transplants other than those specifically named in this Policy.
- Maternity Service, including related services and supplies.
- 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.
- Elective sterilization.
- Routine Inpatient Hospital nursery charges and the routine Inpatient examination of a newborn when the mother's charges for Maternity Service are not paid under this Policy.

HOW TO FILE A CLAIM

CLAIM FILING

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. However, it is your responsibility to insure that the necessary Claim information has been provided to Blue Cross and Blue Shield.

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

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

1. Complete a Major Medical Claim Form. These are available from Blue Cross and Blue Shield.
2. Attach all bills that are 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, a description of the service and the Claim Charge.
3. Mail the completed Claim Form with attachments to:

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

In any case, Claims must be filed no later than December 31st of the calendar year following the year in which the Covered Service was rendered. For the purposes of this filing time limit, Covered Services rendered in December will be considered to have been rendered in the next calendar year.

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

CLAIM PAYMENT

When Blue Cross and Blue Shield receives a Claim, it will be processed and notice of the disposition will be sent to you and your Provider. In most cases, benefit payments will be sent directly to the Provider. In some cases, the payments will be sent directly to you (for example, when you have already paid your Provider).

CLAIM REVIEW PROCEDURES

Blue Cross and Blue Shield will pay all Claims within 30 days of receipt of all information required to process a Claim. In the event that Blue Cross and Blue Shield does not process your Claim within this 30-day period, you will 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.

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

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

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

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

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

DEPARTMENT OF INSURANCE ADDRESS

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

**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**

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.

Blue Cross and Blue Shield may receive such payments, discounts and/or other allowances during the term of this Policy. You are not entitled to receive any portion of any such payments, discounts and/or other allowances. However, in the case of Hospitals and other facilities, the calculation of any out-of-pocket maximums or any maximum amount 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.

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 usually 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 actually pays, and you are not entitled to any part of these savings.

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 at a Non-Plan Hospital. 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. A Covered Person's 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 a Covered Person. 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. PROVIDER RELATIONSHIPS

- a. The choice of a Provider is solely your choice and Blue Cross and Blue Shield will not interfere with your relationship with any Provider.
- b. Blue Cross and Blue Shield does not itself undertake to furnish health care services, but solely to make payments to Providers for the Covered Services received by you. Blue Cross and Blue Shield is not in any event liable for any act or omission of any Provider or the agent or employee of such Provider, including, but not limited to, the failure or refusal to render services to you. Professional services which can only be legally performed by a Provider are not provided by Blue Cross and Blue Shield. Any contractual relationship between a Physician and a Plan Hospital or other Plan Provider shall not be construed to mean that Blue Cross and Blue Shield is providing professional service.
- c. The use of an adjective such as Plan or Participating in modifying a Provider shall in no way be construed as a recommendation, referral or any other statement as to the ability or quality of such Provider. In addition, the omission, non-use or non-designation of Plan, Participating or any similar modifier or the use of a term such as Non-Plan or Non-PPO should not be construed as carrying any statement or inference, negative or positive, as to the skill or quality of such Provider.

4. ENTIRE POLICY; CHANGES

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

5. NOTICES

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

6. INFORMATION AND RECORDS

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

7. LIMITATIONS OF ACTIONS

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

8. DEATH OF A COVERED PERSON - REFUND OF PREMIUMS

Blue Cross and Blue Shield will refund any unearned premium assessed following the death of any person covered under this Policy; provided, however, that a written request for a premium refund is received from the representative of the estate of the deceased or the person or entity so entitled.

9. TIME LIMIT ON CERTAIN DEFENSES

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

10. APPLICABLE LAW

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

11. SERVICE MARK REGULATION

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

REIMBURSEMENT PROVISION

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

- a. to immediately reimburse Blue Cross and Blue Shield for any payments received, whether by action at law, settlement or otherwise, in the amount of the total Eligible Charge for Covered Services for which Blue Cross and Blue Shield has provided benefits irrespective of any separate financial arrangement between any Plan Provider and Blue Cross and Blue Shield.
- b. that Blue Cross and Blue Shield will have a lien to the extent of the total Eligible Charge for Covered Services provided. Such lien may be filed with the person whose act caused the injury, the person's agent or a court having jurisdiction in the matter.

It is your responsibility to furnish any information, assistance or provide any documents that Blue Cross and Blue Shield may request in order to obtain its rights under this provision. (See provisions of this Policy regarding "BLUE CROSS AND BLUE SHIELD'S SEPARATE FINANCIAL ARRANGEMENTS WITH PROVIDERS.")

DEFINITIONS

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 contain important limitations and special conditions that are applicable to your benefits.

Ambulance Transportation means local transportation in a specially equipped duly certified vehicle from your home or 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 when such Hospital or Skilled Nursing Facility would ordinarily be expected to have the appropriate facilities for the treatment needed and would be the nearest facility from the place where such transportation began or from the destination of such transportation. If there are no facilities in the local area equipped to provide the care needed, Ambulance Transportation then means 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 is duly licensed by the appropriate state and local authority to provide such services.

Plan Freestanding Ambulatory Surgical Facility means an Ambulatory Surgical Facility which has a written agreement with Blue Cross and Blue Shield to provide services to you at the time services are rendered to you.

Non-Plan Ambulatory Surgical Facility..... means an Ambulatory Surgical Facility which does not have an agreement with Blue Cross and Blue Shield.

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

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

Certified Registered Nurse Anesthetist (CRNA) means a person who (1) is a graduate of an approved school of nursing and is duly licensed as a registered nurse; (2) 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; (3) has been certified by the Council of Certification of Nurse Anesthetists or its predecessors; and (4) is recertified every two years by the Council on Recertification of Nurse Anesthetists.

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

Claim means notification in a form acceptable to Blue Cross and Blue Shield that service has been rendered or furnished to you. This notification must set forth in full the details of such service including, but not limited to, your name, age, sex and identification number, the name and address of the Provider, a specific 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 irrespective of any separate financial arrangement between Blue Cross and Blue Shield and the 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, upon submission of a Claim, in accordance with the benefits specified in this Policy. All Claim Payments will be calculated on the basis of the Eligible Charge for Covered Services rendered to you, irrespective of any separate financial arrangement between Blue Cross and Blue Shield and the particular Provider. (See provisions of this Policy regarding BLUE CROSS AND BLUE SHIELD'S SEPARATE FINANCIAL ARRANGEMENTS WITH PROVIDERS.)

Coinsurance..... means a percentage of an eligible expense that a Covered Person is required to pay toward a Covered Service

Complications of Pregnancy means all physical effects suffered which have been directly caused by pregnancy but which would not be considered the effect of a normal pregnancy.

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

Plan Coordinated Home Care Program means a Coordinated Home Care Program which has a written agreement with Blue Cross and Blue Shield to provide service to you at the time services are rendered to you.

Non-Plan Coordinated Home Care Program means a Coordinated Home Care Program which does not meet the definition of a Plan Coordinated Home Care Program, but which 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 commences.

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

Custodial Care Services means those services which do not require the technical skills or professional training of medical and/or nursing personnel in order to be safely and effectively performed. Custodial Care Services include, but are not limited to, such things as: assistance with activities of daily living (bathing, personal hygiene, feeding, meal preparation); administration of oral medications; assistance with ambulation or walking; assistance with supportive or maintenance physical therapy; care due to incontinency; turning and/or positioning in bed; acting as a companion or sitter; nurses aid services. Custodial Care Services also means the provision of Inpatient services and supplies to you when you are not receiving Skilled Nursing Services on a continuous basis and/or are not under a specific therapeutic program which has a reasonable expectancy of effecting improvement in your condition within a reasonable period of time and which can only be safely and effectively administered to an Inpatient in the health care facility involved.

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

Dentist means a duly licensed dentist.

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

Dialysis Facility 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 is duly licensed by the appropriate governmental authority to provide such services.

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

Non-Plan Dialysis Facility means a Dialysis Facility which does not meet the definition of Plan Dialysis Facility but which has been certified in accordance with the guidelines established by Medicare.

Eligible Charge means (1) in the case of a Provider which has a written agreement with Blue Cross and Blue Shield, such Provider's Claim Charge for Covered Services, and (2) in the case of a Provider which does not have a written agreement with Blue Cross and Blue Shield, either of the following charges for Covered Services as determined at the discretion of Blue Cross and Blue Shield: (a) the charge which the particular Hospital or facility usually charges its patients for Covered Services; or (b) the charge which is within the range of charges other similar Hospitals or facilities within similar geographic areas charge their patients for the same or similar services, as reasonably determined by Blue Cross and Blue Shield. Further, if Covered Services are rendered in a State which by statute mandates the amount of the Claim Charge for Covered Services, the Claim Charge shall mean the amount prescribed by such statute.

Emergency Accident Care means the initial Outpatient treatment of accidental injuries including necessary related Diagnostic Services.

Emergency Medical Care.....means services provided for the initial Outpatient treatment, including related Diagnostic Services, of the sudden and unexpected onset of a medical condition that the absence of immediate medical attention would likely result in serious and permanent medical consequences.

Examples of medical conditions are: severe chest pains, convulsions or persistent severe abdominal pains.

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 (the Insured) and your eligible dependents under this Policy.

Hospice Care Program Provider.....means an organization duly licensed to provide Hospice Care Program Service.

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

Hospital means a facility which is 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 include health resorts, rest homes, nursing homes, Skilled Nursing Facilities, convalescent homes, custodial homes for the aged or similar institutions.

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

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

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

Non-PPO Hospital (Non-Participating Provider Hospital) means a Hospital which does not meet the definition of PPO Hospital.

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

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

Insured means the person who has applied for coverage under this Policy and to whom Blue Cross and Blue Shield has issued an identification card.

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

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

Medical Care means the ordinary and usual professional services rendered by a Physician during a professional visit for treatment of an illness or injury. Medical Care does not include any professional service rendered by a Physician that is otherwise specified as a Covered Service in this Policy.

Medically Necessary - SEE THE EXCLUSIONS SECTION OF THIS POLICY.

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

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.

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.

Other Coverage means any plan or policy which provides insurance, reimbursement or benefits for hospital, surgical or other medical expenses, including individual or group health insurance policies; another policy or plan with Blue Cross and Blue Shield; HMO coverages; and self-insured group plans. Other Coverage does not include insurance or coverage which is not related to the type of medical expenses incurred but is based upon payment of a fixed dollar amount per day.

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

Participating Provider Option (PPO) means a program of health care benefits designed to provide you with economic incentives for using designated Providers of health care services.

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

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

Podiatrist means a duly licensed podiatrist.

Policy means this booklet, the Schedule Page and 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 that was diagnosed or treated by a Provider within twelve months prior to your Coverage Date or which produced symptoms within twelve months prior to your Coverage Date which would have caused an ordinarily prudent person to seek medical diagnosis or treatment.

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

Provider means any health care facility, person or entity duly licensed to render Covered Services to you.

Plan Provider means a Provider which has a written agreement with Blue Cross and Blue Shield to provide services to you at the time services are rendered to you.

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

Medicare Participating Provider means a Provider which has been certified by the Department of Health and Human Services for participation in the Medicare Program.

Renal Dialysis Treatment means one unit of service including the equipment, supplies and administrative service which are customarily considered as necessary to perform the dialysis process.

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

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

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

Uncertified Skilled Nursing Facility means a Skilled Nursing Facility which does not meet the definition of 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 technical skills and professional training of an R.N. or L.P.N. and which services cannot reasonably be taught to a person who does not have such specialized skill and professional training. The inherent complexity of the service provided must be such that the service can safely and effectively be performed only by professional licensed (R.N. or L.P.N.) nursing personnel. Skilled Nursing Services do not include Custodial Care Services.

Speech Therapy means 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, tranquilizers, amphetamines 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.

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

Temporomandibular Joint Dysfunction and Related Disorders (TMJ) means jaw joint conditions including temporomandibular joint disorders and craniomandibular disorders, and all other conditions of the joint linking the jaw bone and skull and the complex of muscles, nerves and other tissues relating to that joint.

Usual and Customary Fee (U&C Fee) means the fee as reasonably determined by Blue Cross and Blue Shield which is based on the fee which the Physician, Dentist or Podiatrist who renders the particular service usually charges his patients for the same service and the fee which is within the range of usual fees other Physicians, Dentists or Podiatrists of similar training and experience in a similar geographic area charge their patients for the same service, under similar or comparable circumstances. However, if Blue Cross and Blue Shield reasonably determines that the Usual and Customary Fee for a particular service is unreasonable because of extenuating or unusual circumstances, the Usual and Customary Fee for such service shall mean the reasonable fee as reasonably determined by Blue Cross and Blue Shield.

INDEX

A

- Ambulance Transportation, 18
 - definition of, 29
- Average Discount Percentage ("ADP")
 - definition of, 29

C

- Case Management, under MSA, 9
- Cardiac Rehabilitation Services, with an organ transplant, 19
- Chemotherapy, 13, 17
 - definition of, 30
- Claim
 - definition of, 30
 - filing procedures, 23
 - payment of, 23, 26
 - review procedures, 23
- Complications of Pregnancy, 19
 - See also* Maternity Service
 - definition of, 30
- Consultations, 17
- Coordinated Home Care Program, 13
 - definition of, 30

D

- Death of a Covered Person, refund of premiums, 27
- Death of the Insured, 4
- Deductibles, 6
- Dental Accident Care, 18
- Department of Insurance, 24
- Dependent Children
 - limiting age, 3
 - loss of eligibility, 4

- Diagnostic Services
 - definition of, 31
 - exclusion of, 21
 - with Emergency Accident Care, 31
 - with Emergency Medical Care, 31
- Divorce, 4

E

- Emergency Accident Care, 12, 16
 - definition of, 31
- Emergency Admissions, 13
 - and MSA, 9
- Emergency Medical Care, 14, 17
 - definition of, 31

F

- Family Coverage, 3
 - changing to, 3
 - definition of, 31

H

- Human Organ Transplants, 9
- Hospice, 15
 - definition of, 31

I

- Individual Coverage, 3
 - changing to, 4
 - definition of, 30
- Insured, definition of, 32

L

- Lifetime Maximum, 7

M

- Mammograms, 14, 17

Maternity Service
See also Complications of Pregnancy
definition of, 32
exclusion of, 22

Medical Care, 16
definition of, 32

Medical Services Advisory Program (MSA), 9
Copayment for non-compliance, 11

Medically Necessary
and MSA, 10
exclusion of non-Medically Necessary
services and supplies, 20

Medicare Eligibility, 4

Mental Illness
definition of, 32
exclusion of treatment of, 21

O

Out-of-Pocket Expense Limit, 6

P

Pre-Admission Testing, 12

Preexisting Condition
definition of, 32
waiting period, 6

Pregnancy, Complications of. *See*
Complications of Pregnancy

Premium Payment, 5

Private Duty Nursing Service
definition of, 33

exclusion of, 22

Prosthetic Appliances, 18

R

Radiation Therapy, 13, 17

Renal Dialysis Treatments, 12

S

Substance Abuse, definition of, 33

Substance Abuse Rehabilitation Treatment
definition of, 33
exclusion of, 21

Surgery, 13, 16
assistant surgeon, 16
definition of, 33
oral Surgery, 16

T

Temporomandibular Joint Dysfunction (TMJ)
definition of, 3
exclusion of, 22

Termination of Coverage
death of Insured, 4
dependent child loss of eligibility, 4
divorce, 4
extension of benefits in case of, 5
Medicare eligibility, 4
non-payment of premium, 5
reinstatement, 5



**BlueCross BlueShield
of Illinois**

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

RIDER TO THE POLICY

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

DEFINITIONS SECTION

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

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

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

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

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

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

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

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

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

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

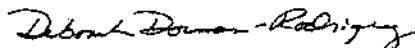
Blue Cross and Blue Shield of Illinois will utilize the same Claim processing rules and/or edits that it utilizes in processing all professional Provider Claims which may also alter the Usual and Customary Charge for a particular service. In the event Blue Cross and Blue Shield of Illinois does not have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

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

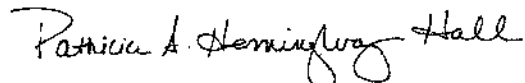
Except as amended by this Rider, all other terms, conditions, limitations and exclusions of the Policy, to which this Rider is attached, will remain in full force and effect.

Attest:

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



Deborah Dorman-Rodriguez
Secretary



Patricia A. Heminway Hall
President

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

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

A. DEFINITIONS SECTION

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

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

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

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

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

B. HOSPITAL BENEFIT SECTION

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

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

C. PHYSICIAN BENEFIT SECTION

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

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

D. SPECIAL CONDITIONS AND PAYMENTS

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

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

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

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

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

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

b. HABILITATIVE SERVICES

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

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

c. ROUTINE MAMMOGRAMS

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

- one baseline mammogram for women age 35-39
- an annual mammogram for women age 40 or older

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

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

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

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

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

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

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

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

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

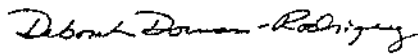
E. EXCLUSIONS-WHAT IS NOT COVERED

1. The exclusion for **Investigational Services and Supplies** is deleted and replaced with the following:
Investigational Services and Supplies and all related services and supplies, except as may be provided under your Policy for a) the cost of routine patient care associated with Investigational cancer treatment, if those services or supplies would otherwise be covered under the Policy if not provided in connection with an approved clinical trial program and b) applied behavior analysis used for the treatment of Autism Spectrum Disorder(s).
2. The exclusion for **Speech Therapy** is deleted and replaced with the following:
Speech Therapy when rendered for the treatment of psychosocial speech delay, behavioral problems (including impulsive behavior and impulsivity syndrome), attention disorder, conceptual handicap or mental retardation, except as may be provided under your Policy for Autism Spectrum Disorder(s).
3. The following exclusion is added:
Habilitative Services that are solely educational in nature or otherwise paid under State or Federal law for purely educational services.

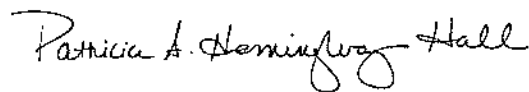
Except as amended by this Rider, all other terms, conditions, limitations and exclusions of the Policy, to which this Rider is attached, will remain in full force and effect.

Attest:

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



Secretary



President

RIDER TO THE POLICY REGARDING DEPENDENT LIMITING AGE

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

COVERAGE AND PREMIUM INFORMATION

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

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

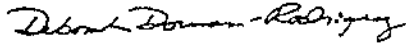
Enrolled unmarried children will be covered up to age 30 if they:

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

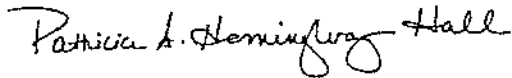
Except as amended by this Rider, all other terms, conditions, limitations and exclusions of the Policy to which this Rider is attached will remain in full force and effect.

Attest:

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



Deborah Dorman-Rodriguez
Secretary



Patricia A. Hemingway Hall
President and CEO

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

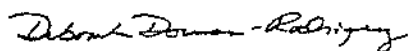
If your Policy includes benefits for Wellness Care, the following provision is added as the last paragraph under WELLNESS CARE section of your Policy:

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

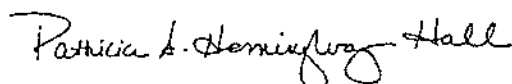
Except as amended by this Rider, all other terms, conditions, limitations and exclusions of the Policy, to which this Rider is attached, will remain in full force and effect.

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

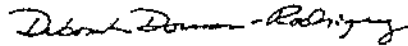
If your Policy includes benefits for Wellness Care, the last paragraph under the WELLNESS CARE section of your Policy is deleted and replaced with the following:

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 Dornan-Rodriguez
Secretary

DB-A69 HCSC

OMNIBUS RIDER TO THE POLICY

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

DEFINITIONS SECTION

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

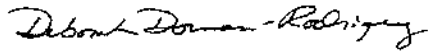
ELIGIBLE CHARGE....means (a) in the case of a Provider which has a written agreement with Blue Cross and Blue Shield to provide care to you at the time Covered Services are rendered, such Provider's Claim Charge for Covered Services and (b) in the case of a Provider which does not have a written agreement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

- (i) the amount that Centers for Medicare and Medicaid ("CMS") reimburses the Hospitals or facilities in similar geographic areas for the same or similar services rendered to members in the Medicare program; or
- (ii) the charge which is within the range of charges other similar Hospitals or facilities in similar geographic areas charge their patients for the same or similar services; or
- (iii) the charge which the particular Hospital or facility usually charges its patients for Covered Services.

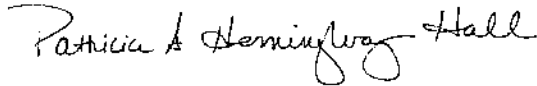
Except as amended by this Rider, all other terms, conditions, limitations and exclusions of the Policy, to which this Rider is attached, will remain in full force and effect.

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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. HOSPITAL BENEFIT SECTION

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

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

B. PHYSICIAN BENEFIT SECTION

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

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

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

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

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

Chiropractic and Osteopathic Manipulation

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

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

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

C. OTHER COVERED SERVICES

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

D. EXCLUSIONS – WHAT IS NOT COVERED

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

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

E. HOW TO FILE A CLAIM

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

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

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

or

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

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

Attest:

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



Raymond F. McCaskey
President



Thomas C. Lubben
Secretary

OMNIBUS RIDER TO THE POLICY

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

A. GUARANTEED RENEWABILITY

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

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

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

B. DEFINITIONS SECTION

The following will be added to the DEFINITIONS SECTION:

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

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

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

Attest:

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



Raymond F. McCaskey
President



Thomas C. Lubben
Secretary

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

DB-A61 HCSC



Standard Authorization Form

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

Form with fields: 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.

Table with 4 columns: 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
[] Claims
[] Service Determination Information
[] Premium
[] Services from [provider or supplier]
[] Other

Form with lines for dates of services

(Specify other information that is not listed in one of the categories above.)

IV. Expiration and Revocation

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

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

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

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

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

Signature

Date: month/day/year

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

Personal Representative's Name

Relationship to Individual

Personal Representative's Address

City

State

ZIP

Personal Representative's Area Code & Telephone Number

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

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

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

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



BlueCross BlueShield of Illinois

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

Blue Access for Members^{SM*}

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 for Members is not available on child only policies.*

Blue Access MobileSM

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!

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.

All registered trademarks and service marks are the property of their respective owners.

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

31613.0413

Well onTargetSM

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.

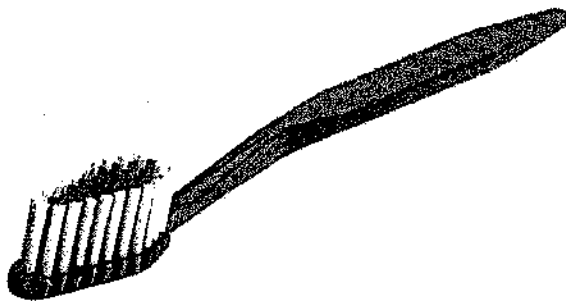
Well onTarget includes wellness programs such as:

- OnmywayTM 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

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 VisionSM 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.

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.

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.

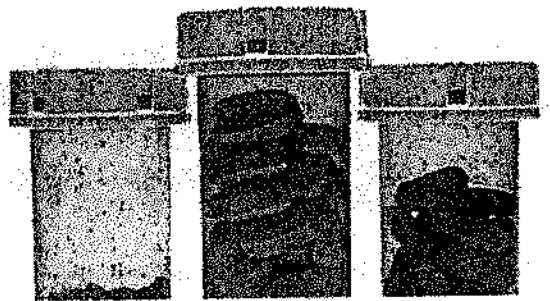
** Proof of Blue Cross and Blue Shield of Illinois coverage is needed. The \$0 enrollment fee offer is only for new members who enroll online at www.Blue365Deals.com/BCBSIL/. A \$35 administrative fee applies to all memberships. Monthly dues and taxes may also apply. Members' prices, dues and fees may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



Twitter

twitter.com/bcbsil

YouTube

youtube.com/bcbsil

**RIDER TO THE POLICY TO IMPLEMENT
ILLINOIS WELLNESS COVERAGE**

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

The changes below are effective June 1, 2010.

GENERAL PROVISIONS

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

VALUE BASED DESIGN PROGRAMS

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

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

Attest:

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


Karen Atwood
President

RIDER TO THE POLICY

Effective Date: 10/01/2010

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

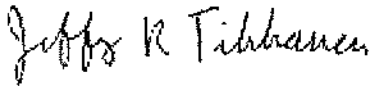
EXCLUSIONS—WHAT IS NOT COVERED

The hearing aid exclusion is revised to read as follows:

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

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

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



Jeffrey R. Tikkanen
President, Retail Markets

RIDER TO THE POLICY

Effective Date: January 1, 2012

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

GENERAL PROVISIONS

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

PREMIUM REBATES, PREMIUM ABATEMENTS AND COST-SHARING

- a. **Rebate.** In the event federal or state law requires Blue Cross and Blue Shield to rebate a portion of annual premiums paid, Blue Cross and Blue Shield will directly provide any rebate owed participants or former participants to such persons in amounts as required by law.
- b. **Abatement.** Blue Cross and Blue Shield may from time to time determine to abate (all or some of) the premium due under this Policy for particular period(s).

Any abatement of premium by Blue Cross and Blue Shield represents a determination by Blue Cross and Blue Shield not to collect premium for the applicable period(s) and does not effect a reduction in the rates under this Policy. An abatement for one period shall not constitute a precedent or create an expectation or right as to any abatement in any future periods.
- c. Blue Cross and Blue Shield makes no representation or warranty that any rebate or abatement owed or provided is exempt from any federal, state or local taxes (including any related notice, withholding or reporting requirements). It will be the obligation of each participant or former participant (if applicable) owed or provided a rebate or an abatement to determine the applicability of and comply with any applicable federal, state or local laws or regulations.
- d. **Cost-Sharing.** Blue Cross and Blue Shield reserves the right from time to time to waive or reduce the Coinsurance, Copayments and/or Deductibles under this Policy.

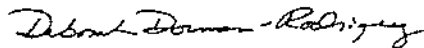
The provisions of this Rider shall be in addition to (and do not take the place of) the other terms and conditions of this Policy.

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

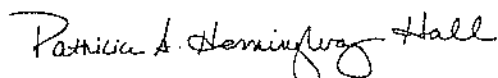
Except as amended by this Rider, all other terms, conditions, limitations and exclusions of the Policy to which this Rider is attached will remain in full force and effect.

Attest:

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



Deborah Dorman-Rodriguez
Secretary



Patricia A. Hemingway Hall
President

DB-A86 HCSC

\$500, \$1,000 or \$2,500 Deductible

Outline of Coverage

Basic Hospital and Medical/Surgical Expense Coverage



**BlueCross BlueShield
of Illinois**

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

DIRECT MARKETS

(POLICY DB-26 HCSC)

Basic Hospital and Medical/Surgical Expense Coverage

\$500, \$1,000 or \$2,500 Deductible

Outline of Coverage

- 1. READ YOUR POLICY CAREFULLY—**
This outline of coverage provides a brief description of the important features of your Policy. This is not the insurance contract, and only the actual Policy provisions will control. The Policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you **READ YOUR POLICY CAREFULLY!**
- 2. Basic Hospital and Medical/Surgical Expense Coverage —**
Policies of this category are designed to provide, to persons insured, coverage for Hospital and medical/surgical expenses incurred as a result of a covered accident or sickness. Coverage is provided for daily Hospital room and board, miscellaneous Hospital services, Hospital Outpatient services, surgical services, anesthesia services, and In-Hospital medical services, subject to any limitations, Deductibles, and Copayment requirements set forth in the Policy. Coverage is not provided for unlimited Hospital or medical/surgical expenses.

BENEFITS	PARTICIPATING PROVIDER COVERAGE
Lifetime Benefit	\$5,000,000
Deductible Per individual, per calendar year.* (If two or more family members receive covered services as a result of injuries received in the same accident, only one Deductible will apply.)	\$500, \$1,000, or \$2,500
Family Deductible Equal to three times the individual Deductible per family, per calendar year.	\$1,500, \$3,000, or \$7,500
Carryover Deductible If an insured incurs covered expenses for the Deductible in the last three months of the calendar year, we will carry over that amount as a credit toward the Deductible for the next following calendar year.	
Inpatient Hospital Services Includes semi-private room and board; intensive care and related miscellaneous expenses for services and supplies including pre-admission testing; prescription drugs; services of a registered physical, occupational, or speech therapist; initial expense for artificial limbs; prosthetic devices; oxygen and its administration; blood and blood plasma.	80%
Inpatient Diagnostic Services Including, but not limited to, X-rays, lab tests, EKGs, ECGs, pathology services, pulmonary function studies, radioisotope tests, and electromyograms.	80%
Outpatient Diagnostic Services Including, but not limited to, X-rays, lab tests, EKGs, ECGs, pathology services, pulmonary function studies, radioisotope tests, and electromyograms ONLY when (1) rendered on the same day as and in connection with Surgery, or (2) as part of covered emergency care.	80%
Inpatient Physician Charges (Medical/Surgical Services) For treatment due to accident or illness while an inpatient in a hospital, Skilled Nursing Facility, or Coordinated Home Care Program; surgeon, assistant surgeon, and anesthesiologist fees (mental illness and substance abuse charges are NOT covered; outpatient physician charges are covered ONLY when related to emergency care.)	80%
Outpatient Surgery Includes surgeon, assistant surgeon, and anesthesiologist fees; also includes surgical and anesthetic services and supplies; pre-operative tests related to the surgery.	80%

Emergency Care (Hospital and Physician) (Deductible does not apply.)

Copayment applies to Covered Services received in a Hospital emergency room or a Physician's office. \$125 copayment*,
 Copayment does not apply to Covered Services provided for the treatment of criminal sexual assault or abuse. then 80%

Other Outpatient Services Includes radiation therapy, chemotherapy, and renal dialysis treatments; and mammograms; and local ambulance service when related to covered Hospital admission or covered emergency care.

80%

Human Organ and Tissue Transplants Includes expenses for cornea, kidney, bone marrow, heart valve, muscular/skeletal, parathyroid, heart, lung, heart/lung, liver, pancreas, or pancreas/kidney and inpatient and outpatient immunosuppressive drugs related to transplant.

80%

Out-of-Pocket Expense Limits The amount of money an individual pays toward covered expenses during any one calendar year, excluding the Deductibles. MSA copayment, emergency care copayment, charges in excess of Usual and Customary Allowances, deductibles, and items asterisked (*) do not apply to any out-of-pocket limit.

	\$1,000	or	\$ 2,000
If using participating providers	\$1,000		\$ 2,000
If using non-participating providers	\$5,000		\$10,000

Family Out-of-Pocket Expense Limits Equal to three times the individual out-of-pocket limit (either \$1,000 or \$2,000), per family, per calendar year.

If using participating providers	\$ 3,000		\$ 6,000
If using non-participating providers	\$15,000		\$30,000

Medical Services Advisory (MSA[®]) The MSA helps you maximize your benefits. Notification required prior to all elective hospital admissions. Emergency and maternity admission notification required within two working days of admission. If individual does not notify MSA or follow advice given, hospital benefits are reduced by \$1,000*.

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

A \$300-per-admission deductible will apply in addition to the individual or family deductible*. Hospital benefits shown above, which are paid at 80% at participating hospitals, are paid at 60% at non-participating hospitals and 50% at non-plan hospitals, except for outpatient hospital emergency care which is always paid at 80%, regardless of the hospital selected. The out-of-pocket expense limit is \$5,000 or \$10,000 (depending upon which out-of-pocket expense limit is chosen) when non-participating providers are used. The family out-of-pocket expense limit is \$15,000 or \$30,000 (depending upon which out-of-pocket expense limit is chosen) when non-participating providers are used.

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

Pre-Existing Conditions Limitation

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

Premiums

We may change premium rates only if we do so on a class basis for all DB-26 HCSC policies. Premiums can be changed based on age, sex, and rating area.

Guaranteed Renewability

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

- If all Policies bearing form number DB-26 HCSC are not renewed, written notice will be provided at least 90 days before coverage is discontinued. Furthermore, you may convert to any other individual policy Blue Cross and Blue Shield offers to the individual market.
- In the event of fraud or an intentional misrepresentation of material fact under the terms of the coverage, written notice will be given at least 30 days before coverage is discontinued.

Exclusions and Limitations:

Hospitalization, services, and supplies which are not Medically Necessary. Services or supplies that are not specifically mentioned in the 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; 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 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; custodial care service; outpatient medical care, including but not limited to routine physical examinations; immunizations; Outpatient Diagnostic Service except when rendered on the same day as and in connection with Surgery, as part of covered Emergency Accident Care or Emergency Medical Care, or when rendered in connection with Chemotherapy or radiation therapy treatment; outpatient drugs or medicines except for immunosuppressive drugs prescribed in connection with a human organ transplant; services or supplies rendered for substance abuse rehabilitation treatment or for the treatment of mental illness; 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; cosmetic surgery and related services and supplies, except for the correction of congenital deformities or for conditions resulting from accidental injuries, tumors, or diseases; services or supplies received from a dental or medical department or clinic maintained by an employer, labor union, or other similar person or group; services or supplies for which you are not required

to make payment or would have no legal obligation to pay if you did not have this or similar coverage; charges for failure to keep a scheduled visit or charges for completion of a claim form; personal hygiene, comfort, or convenience items commonly used for other than medical purposes, such as air conditioners, humidifiers, physical fitness equipment, televisions, and telephones; medical equipment or special braces, splints, specialized equipment, appliances, ambulatory apparatus, or battery or atomically controlled implants, except as specifically mentioned in this Policy; blood derivatives which are not classified as drugs in the official formularies; private-duty nursing service; eyeglasses, contact lenses, or cataract lenses and the examination for prescribing or fitting of glasses or contact lenses or for determining the refractive state of the eye; hearing aids or examinations for the prescription or fitting of hearing aids; services and supplies rendered in connection with Temporomandibular Joint Dysfunction and related disorders except as otherwise specifically mentioned in the Policy; treatment of flat foot conditions and the prescription of supportive devices for such conditions, treatment of subluxations of the foot, routine foot care, or corrective shoes; procurement or use of prosthetic devices, special appliances, or surgical implants which are for cosmetic purposes, the comfort and convenience of the patient, or unrelated to the treatment of a disease or injury; replacement or repair of or adjustments to prosthetic devices, special appliances, or surgical implants; Outpatient occupational, physical, or speech therapy; services and supplies rendered or provided for human organ or tissue transplants other than those specifically named in this Policy; normal obstetrical service including related services and supplies; 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; elective sterilization.



**BlueCross BlueShield
of Illinois**

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

DIRECT MARKETS

® Registered Service Marks of the Blue Cross and Blue Shield Association,
an Association of Independent Blue Cross and Blue Shield Plans

® Registered Service Mark of Health Care Service Corporation

BILOC294

**Rider to the Policy Regarding
Blue Cross and Blue Shield's Separate Financial
Arrangements With Providers**

Effective Date of Rider: July 1, 1996

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

A. DEFINITIONS

The following definition is hereby added to the DEFINITIONS SECTION of your Policy:

"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.

B. GENERAL PROVISIONS

The description of BLUE CROSS AND BLUE SHIELD'S SEPARATE FINANCIAL ARRANGEMENTS WITH PROVIDERS in your Policy is hereby amended in its entirety to read as follows:

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:

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 this 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.

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

Attest:

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


Secretary


President

**Rider to the Policy Regarding the Health Insurance
Portability and Accountability Act of 1996 (HIPAA)**

(Applicable to Policies DB-19 HCSC, DB-20 HCSC, DB-22 HCSC,
DB-23 HCSC, DB-24 HCSC, DB-25 HCSC, DB-26 HCSC,
DB-27 HCSC and DB-32 HCSC)

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

CONDITIONAL RENEWABILITY

The provision in your Policy entitled **CONDITIONAL RENEWABILITY** is hereby deleted in its entirety and replaced with the following:

GUARANTEED RENEWABILITY

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

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

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

DEFINITIONS SECTION

The following definitions are hereby added:

Certificate Of Creditable Coveragemeans a certificate disclosing information relating to your Creditable Coverage under a health care benefit program for purposes of reducing any Preexisting Condition exclusion imposed by any group health plan coverage.

Creditable Coverage.....means coverage you had under any of the following:

- (i) a group health plan;
- (ii) health insurance coverage for medical care under any hospital or medical service policy or HMO contract offered by a health insurance issuer;
- (iii) Medicare (Part A or B of Title XVIII of the Social Security Act);
- (iv) Medicaid (Title XIX of the Social Security Act);
- (v) CHAMPUS (Title 10 U. S. C. Chapter 55);
- (vi) the Indian Health Service or of a tribal organization;
- (vii) a State health benefits risk pool;
- (viii) the Federal Employees Health Benefits Program;
- (ix) a public health plan maintained by a State, county or other political subdivision of a State;
- (x) Section 5(e) of the Peace Corps Act.

The following provision is hereby added to the **COVERAGE AND PREMIUM INFORMATION** section of your Policy:

CERTIFICATE OF CREDITABLE COVERAGE

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

MEDICARE ELIGIBILITY

All references in this Policy regarding automatic termination of your coverage under this Policy due to Medicare eligibility are hereby deleted.

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

Attest:

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


Secretary


President

**Rider to the Policy Regarding Other
Blue Cross and Blue Shields' Separate Financial
Arrangements With Providers**

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

The BLUE CROSS AND BLUE SHIELD'S SEPARATE FINANCIAL ARRANGEMENTS WITH PROVIDERS provision in the GENERAL PROVISIONS section of your Policy is hereby amended to add the following:

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

Blue Cross and Blue Shield hereby informs you that other Blue Cross and Blue Shield Plans outside of Illinois ("Host Plans") may have contracts similar to the contracts described in BLUE CROSS AND BLUE SHIELD'S SEPARATE FINANCIAL ARRANGEMENTS WITH PROVIDERS provision with certain Providers ("Host Plan Providers") in their service area.

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

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

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

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

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

Attest:

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


Secretary


President

**Rider to the Policy Regarding
Post-Mastectomy Care**
(applicable to Policies DB-26 ,DB-27 and DB-30)

In compliance with Public Act 90-7, the Policy, to which this Rider is attached and becomes a part, is hereby amended as follows:

The following provision is hereby added to the Physician Benefits section of your Policy:

Post-Mastectomy Care

Benefits for post-mastectomy care are available for either a Physician office visit or a nurse visit in your home to verify your condition in the first 48 hours after discharge from a Hospital.

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

Attest:

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


Secretary


President

Rider to the Policy Regarding Definition Changes

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

DEFINITIONS SECTION

The following definitions are hereby revised to read as follows or are being added to your Policy:

AMBULATORY SURGICAL FACILITY

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.

COORDINATED HOME CARE PROGRAM

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.

DIALYSIS FACILITY

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.

HOSPITAL

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

PROVIDER

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 "Participating Provider" means a Plan Hospital 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 the Participating Provider Option program.

A "Non-Participating Provider" means a Plan Hospital or Professional Provider 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 participants in the Participating Provider Option program.

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.

SKILLED NURSING FACILITY

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.


SUBSTANCE ABUSE TREATMENT FACILITY

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

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

Attest:

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


Secretary


President

**RIDER TO THE POLICY REGARDING CHANGES IN
DEFINITIONS, SPECIAL CONDITIONS AND EXCLUSIONS**

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

A. DEFINITIONS

The definition in your Policy for **Emergency Medical Care** is amended to read:

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

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

B. SPECIAL CONDITIONS

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

Mastectomy-Related Services

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

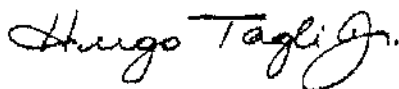
C. EXCLUSIONS- WHAT IS NOT COVERED

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

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

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

Attest:



Secretary

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



President

D. PHYSICIAN BENEFITS

COVERED SERVICES

Chemotherapy and Radiation therapy treatments are hereby amended to read as follows:

Chemotherapy and services and supplies which are customarily considered as necessary to administer the Chemotherapy.

Radiation therapy treatment and services and supplies which are customarily considered as necessary to administer the radiation therapy.

Emergency Medical Care:

The statement that reads: “- **benefits will be provided only if you are admitted to the Hospital as an Inpatient for the same illness within 72 hours of the Emergency Medical Care.**” is hereby deleted.

BENEFIT PAYMENT FOR PHYSICIAN SERVICES

The following paragraph is hereby added:

However, each time you receive Emergency Accident Care or Emergency Medical Care in a Physician’s office, you will be responsible for a Copayment of \$125. The emergency care Copayment does not apply to Covered Services provided for the treatment of criminal sexual assault or abuse.

E. EXCLUSIONS - WHAT IS NOT COVERED

The following exclusions, if applicable, are deleted:

- Outpatient Diagnostic Service except when rendered on the same day as and in connection with Surgery or as part of covered Emergency Accident Care or Emergency Medical Care or additional surgical/medical opinions required by the MSA.

- Emergency Medical Care unless such care is followed by Inpatient admission to a Hospital within 72 hours of the care, unless otherwise specified in the Policy.

- Emergency Medical Care unless such care is followed by Inpatient admission to a Hospital within 72 hours of the care.

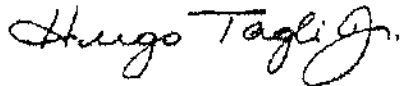
The following exclusion is added:

- Outpatient Diagnostic Service except when rendered on the same day as and in connection with Surgery, as part of covered Emergency Accident Care or Emergency Medical Care, or when rendered in connection with Chemotherapy or radiation therapy treatment.

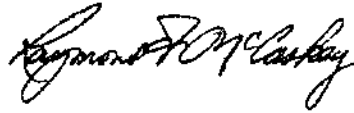
Except as amended by this Rider, all terms and conditions of the Policy to which this Rider is attached shall remain in full force and effect.

Attest:

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



Secretary



President

RIDER TO THE POLICY REGARDING BENEFIT CHANGES

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

A. BENEFITS HIGHLIGHTS

The **Emergency Care** benefit is hereby amended to read as follows:

Emergency Care

Copayment **\$125**

(Copayment applies to Covered Services received in a Hospital emergency room or a Physician's office. Copayment does not apply to Covered Services provided for the treatment of criminal sexual assault or abuse.)

Emergency Accident Care - Hospital and Physician . . . **80% of the Eligible Charge or Usual and Customary Fee, no Deductible**

Emergency Medical Care - Hospital and Physician . . . **80% of the Eligible Charge or Usual and Customary Fee, no Deductible**

B. WAITING PERIOD AND PROGRAM PAYMENT PROVISIONS

OUT OF POCKET EXPENSE LIMIT

The following statement is hereby added to the sections titled **For PPO Hospitals and Physician Covered Services** and **For Non-PPO Hospitals** as an expense which is not eligible to be applied toward the out-of-pocket expense limit.

- Copayments resulting from Covered Services received in connection with Emergency Accident Care and Emergency Medical Care.

C. HOSPITAL BENEFITS

OUTPATIENT COVERED SERVICES

Chemotherapy and Radiation therapy treatments are hereby amended to read as follows:

Chemotherapy and services and supplies which are customarily considered as necessary to administer the Chemotherapy.

Radiation therapy treatment and services and supplies which are customarily considered as necessary to administer the radiation therapy.

Emergency Medical Care

The statement that reads: "**- benefits will be provided only if you are admitted to the Hospital as an Inpatient for the same illness within 72 hours of the Emergency Medical Care .**" is hereby deleted.

BENEFIT PAYMENT FOR OUTPATIENT COVERED SERVICES

The following paragraph is hereby added:

However, each time you receive Emergency Accident Care or Emergency Medical Care in an emergency room, you will be responsible for a Copayment of \$125. The emergency room Copayment does not apply to Covered Services provided for the treatment of criminal sexual assault or abuse.

**RIDER TO THE POLICY REGARDING
EXCLUSIONS AND GENERAL PROVISIONS**

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

1. EXCLUSIONS- WHAT IS NOT COVERED

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

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

2. GENERAL PROVISIONS

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

TIME LIMIT ON CERTAIN DEFENSES

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

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

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

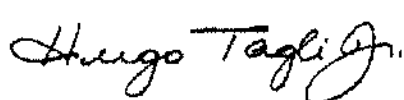
Severability

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

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

Attest:

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



Secretary



President

**RIDER TO THE POLICY REGARDING
REIMBURSEMENT PROVISION**

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

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

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

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

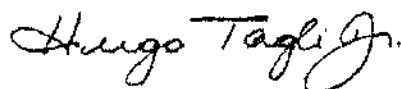
Blue Cross and Blue Shield shall have the right to first reimbursement out of all funds you, your covered dependents, or your legal representative, are or were able to obtain from the same expenses for which Blue Cross and Blue Shield has provided benefits as a result of that sickness or injury.

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

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

Attest:

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



Secretary



President

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

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

1. EXCLUSIONS- WHAT IS NOT COVERED

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

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

2. HOW TO FILE A CLAIM

Under the HOW TO FILE A CLAIM section of your Policy, the first paragraph under the "Claim Review Procedures" provision is deleted in its entirety. The following provision is added immediately preceding the "Claim Review Procedures" provision:

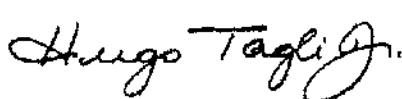
TIME OF PAYMENT OF CLAIMS

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

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

Attest:

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



Secretary



President

**RIDER TO THE POLICY REGARDING
ELIGIBILITY AND PREMIUM INFORMATION**

(Applicable to policies DB-26 HCSC & DB-45 HCSC)

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

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

APPLICATION FOR COVERAGE

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

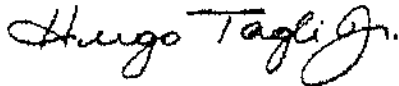
In the event of such cancellation, Blue Cross and Blue Shield will refund any premium paid during the period for which cancellation is effected. However, Blue Cross and Blue Shield will deduct from the premium refund any amounts made in Claim Payments during this period and you will be liable for any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

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

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

Attest:

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



Secretary



President

DB-A45 HCSC

**RIDER TO THE CERTIFICATE OR POLICY REGARDING
DEFINITIONS, HOSPITAL BENEFITS AND PHYSICIAN BENEFITS**

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

A. DEFINITIONS SECTION

1. The definition of **Creditable Coverage** is deleted and replaced with the following:

Creditable Coveragemeans coverage you had under any of the following:

- (i) a group health plan;
- (ii) health insurance coverage for medical care under any hospital or medical service policy or HMO contract offered by a health insurance issuer;
- (iii) Medicare (Parts A, B or C of Title XVIII of the Social Security Act);
- (iv) Medicaid (Title XIX of the Social Security Act);
- (v) military service-related care;
- (vi) the Indian Health Service or of a tribal organization;
- (vii) a State health benefits risk pool;
- (viii) the Federal Employees Health Benefits Program;
- (ix) a public health plan maintained by a State, county or other political subdivision of a State;
- (x) Section 5(e) of the Peace Corps Act.

2. The definition for **Investigational or Investigational Services and Supplies** is replaced with the following:

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

3. The following term and definition is added:

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

B. HOSPITAL BENEFITS or HOSPITAL BENEFIT SECTION

The following is added to the Outpatient Covered Services provision:

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

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

Benefits for colorectal cancer screening will be provided at the benefit payment described in the Wellness Care provision of this Certificate or Policy. Benefits for surgical procedures, such as colonoscopy and sigmoidoscopy, are not provided at the Wellness Care payment level. Such procedures will be provided at the benefit payment level for Surgery described in this Certificate or Policy.

C. MAJOR MEDICAL BENEFIT SECTION or PHYSICIAN BENEFIT SECTION

1. The following paragraph is added to the **Anesthesia Services** provision:

In addition, benefits will be provided for anesthesia administered in connection with dental care treatment rendered in a Hospital or Ambulatory Surgical Facility if (a) a child is age 6 and under, (b) you have a chronic disability, or (c) you have a medical condition requiring hospitalization or general anesthesia for dental care.

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

Assist at Surgery - when performed by a Physician, Dentist or Podiatrist who assists the operating surgeon in performing covered Surgery in a Hospital or Ambulatory Surgical Facility. In addition, benefits will be provided for assist at Surgery when performed by a Physician Assistant or registered nurse practitioner under the direct supervision of a Physician, Dentist or Podiatrist.

3. The colorectal cancer screening Covered Service is deleted in its entirety and replaced with the following:

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

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

Benefits for colorectal cancer screening will be provided at the benefit payment described in the Wellness Care provision of this Certificate or Policy. Benefits for surgical procedures, such as colonoscopy and sigmoidoscopy, are not provided at the Wellness Care payment level. Such procedures will be provided at the benefit payment level for Surgery described in this Certificate or Policy.

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

Attest:


Secretary

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


President

RIDER TO THE CERTIFICATE OR POLICY REGARDING HOSPICE CARE PROGRAM

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

The benefit changes below are effective January 1, 2004.

A. DEFINITIONS SECTION

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

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

B. HOSPICE CARE PROGRAM

The following Hospice Care Program benefit provision is added to your Certificate or Policy replacing any previous Hospice Care Program provision in its entirety:

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 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 should 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. Respite Care Service;
6. Occupational Therapy;
7. Pain management services;
8. Physical Therapy;
9. Physician visits;
10. Social and spiritual services.

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

1. Durable medical equipment;
2. Home delivered meals;
3. Homemaker services;
4. 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 this Certificate or 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.

C. EXCLUSIONS

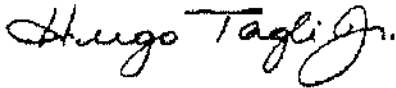
The following exclusion is added:

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

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

Attest:

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



Secretary



President

OMNIBUS RIDER TO THE CERTIFICATE OR POLICY

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

A. DEFINITIONS SECTION

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

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

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

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

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

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

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

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

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

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

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

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

providing care on a continuous Inpatient or Outpatient basis without any clinical improvement by you.

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

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

- (i) the charge which is within the range of charges other similar Hospitals or facilities in similar geographic areas charge their patients for the same or similar services, as reasonably determined by Blue Cross and Blue Shield, if available; or
- (ii) the amount that Centers for Medicare and Medicaid ("CMS") reimburses the Hospitals or facilities in similar geographic areas for the same or similar services rendered to members in the Medicare program; or
- (iii) the charge which the particular Hospital or facility usually charges its patients for Covered Services.

7. If your Certificate or Policy has a Hospice Care Program benefit, the following definition of **Hospice Care Program Service** is added replacing any previous definition of the same name:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

B. MEDICAL SERVICES ADVISORY PROGRAM

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

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

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

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

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

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

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

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

D. ANESTHESIA SERVICES

The following **Anesthesia Services** provision is added to the Physician Benefit Section or Major Medical Benefit Section, depending on your Certificate or Policy, replacing any previous provision of the same name or under the name **Anesthesia**:

Anesthesia Services—if administered at the same time as a covered surgical procedure in a Hospital or Ambulatory Surgical Facility or by a Physician other than the operating surgeon or by a CRNA. However, benefits will be provided for anesthesia services administered by oral and maxillofacial surgeons when such services are rendered in the surgeon's office or Ambulatory Surgical Facility.

In addition, benefits will be provided for anesthesia administered in connection with dental care treatment rendered in a Hospital or Ambulatory Surgical Facility if (a) a child is age 6 and under, (b) you have a chronic disability, or (c) you have a medical condition requiring hospitalization or general anesthesia for dental care.

E. PRIVATE DUTY NURSING SERVICE

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

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

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

Depending on your Certificate or Policy, the **Skilled Nursing Facility Care** provision of the Special Conditions or Special Conditions and Payments section or of the Major Medical Benefit Section; or the **Inpatient Skilled Nursing Facility Care** provision of the Hospital Benefit Section is amended to include the following statement:

No benefits will be provided for admissions to a Skilled Nursing Facility which are for the convenience of the patient or Physician or because care in the home is not available or the home is unsuitable for such care.

G. EXCLUSIONS—WHAT IS NOT COVERED

The **Exclusions – What Is Not Covered** section of your Certificate or Policy is amended as follows:

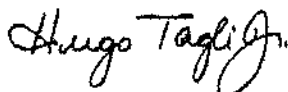
1. The exclusion regarding services and supplies which do not meet accepted standards of medical and/or dental practice is deleted in its entirety and replaced with the following:
 - Services or supplies that do not meet accepted standards of medical and/or dental practice.
2. The following exclusion is added replacing any previous exclusion regarding Investigational Services and Supplies:
 - Investigational Services and Supplies and all related services and supplies, other than the cost of routine patient care associated with Investigational cancer treatment, if those services or supplies would otherwise be covered under the Certificate or Policy if not provided in connection with an approved clinical trial program.

3. The following exclusions are added:

- Long Term Care Service.
- Inpatient Private Duty Nursing Service.
- Maintenance Care.
- Wigs (also referred to as cranial prosthesis).
- Services and supplies rendered or provided for human organ or tissue transplants other than those specifically named in this Certificate or Policy.

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

Attest:



Secretary

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



President

OMNIBUS RIDER TO THE POLICY

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

A. HOSPITAL BENEFIT SECTION

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

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

B. PHYSICIAN BENEFIT SECTION

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

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

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

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

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

Chiropractic and Osteopathic Manipulation

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

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

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

C. OTHER COVERED SERVICES

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

D. EXCLUSIONS – WHAT IS NOT COVERED

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

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

E. HOW TO FILE A CLAIM

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

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

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

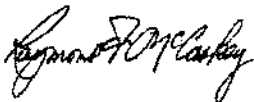
or

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

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

Attest:

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



Raymond F. McCaskey
President



Thomas C. Lubben
Secretary

OMNIBUS RIDER TO THE POLICY

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

A. GUARANTEED RENEWABILITY

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

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

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

B. DEFINITIONS SECTION

The following will be added to the DEFINITIONS SECTION:

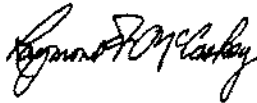
BENEFIT PERIOD.....means a period of one year which begins on January 1st of each year. When you first enroll under this coverage, your first Benefit Period begins on your Coverage Date, and ends on the first December 31st following that date.

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

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

Attest:

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



Raymond F. McCaskey
President



Thomas C. Lubben
Secretary

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

DB-A61 HCSC

OMNIBUS RIDER TO THE POLICY

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

DEFINITIONS SECTION

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

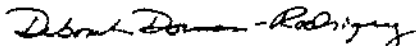
ELIGIBLE CHARGE.....means (a) in the case of a Provider which has a written agreement with Blue Cross and Blue Shield to provide care to you at the time Covered Services are rendered, such Provider's Claim Charge for Covered Services and (b) in the case of a Provider which does not have a written agreement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

- (i) the amount that Centers for Medicare and Medicaid ("CMS") reimburses the Hospitals or facilities in similar geographic areas for the same or similar services rendered to members in the Medicare program; or
- (ii) the charge which is within the range of charges other similar Hospitals or facilities in similar geographic areas charge their patients for the same or similar services; or
- (iii) the charge which the particular Hospital or facility usually charges its patients for Covered Services.

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

Attest:

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



Deborah Dorman-Rodriguez
Secretary



Patricia A. Hemingway Hall
President and CEO

POLICY RIDER
(For Participating Provider Option Plans)

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

A. DEFINITIONS SECTION

The following definitions are added to the Definitions Section:

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 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.

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.

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.

B. PHYSICIAN BENEFIT SECTION

1. The following Covered Service is added to the Physician Benefit Section of your Policy:

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

2. The following Providers are added to the list of Participating Providers in the Physician Benefit Section of your Policy:

- Certified Clinical Nurse Specialists
- Certified Nurse Practitioner
- Durable Medical Equipment Providers
- Home Infusion Therapy Providers

3. The following Providers are added to the list of Non-Participating Providers in the Physician Benefit Section of your Policy:

- Certified Clinical Nurse Specialists
- Certified Nurse Practitioner
- Durable Medical Equipment Providers

C. OTHER COVERED SERVICES

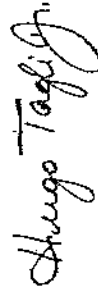
1. The Durable Medical Equipment provision is deleted in its entirety.

2. The following Providers are added to the list of Participating Providers in the Other Covered Services Section of your Policy:

- Certified Clinical Nurse Specialists
 - Certified Nurse Practitioner
 - Durable Medical Equipment Providers
 - Home Infusion Therapy Providers
3. The following providers are added to the list of Non-Participating Providers in the Other Covered Services Section of your Policy:
- Certified Clinical Nurse Specialists
 - Certified Nurse Practitioner
 - Durable Medical Equipment Providers
 - Home Infusion Therapy Providers

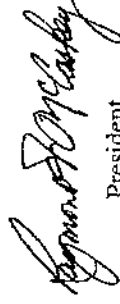
Except as amended by this Rider, all terms, conditions, limitations and exclusions of the Policy to which this Rider is attached will remain in full force and effect.

Attest:



Secretary

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



President