Conversion PPO Plan 500C2

Your Health Care Benefits Policy

Blue Cross
Blue Shield
of Illinois

Health Care Service Corporation,
a Mutual Legal Reserve Company
DB-24 HCSC

RIGHT TO EXAMINE THIS POLICY

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

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 that bears this Policy form number, DB-24 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 233 North Michigan Avenue, Chicago, Illinois each year on the last Tuesday in October at 12:30 p.m.

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

A message from

BLUE CROSS AND BLUE SHIELD

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

THIS POLICY CONTAINS ALL OF THE PROVISIONS OF YOUR HEALTH CARE BENEFIT PROGRAM AND REPLACES ANY PREVIOUS POLICY YOU MAY HAVE BEEN ISSUED BY BLUE CROSS AND BLUE SHIELD.

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

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

Sincerely,

Raymond F. McCaskey
President

Brian Van Vlierbergen
Secretary

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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 $1,000,000

DEDUCTIBLES

Individual Deductible ..... $500 per calendar year

Family Deductible ..... 3 individual deductibles

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

SPECIAL PROGRAMS

The Medical Services Advisory Program MSA*

Notification to the MSA Advisor is required before a non-emergency Inpatient Hospital admission.

Penalty for non-compliance ..... $1,000 reduction of benefits

The Additional Surgical Opinion Program

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

BENEFIT PAYMENT LEVELS

Hospital Benefits

In a **PPO** Hospital ..... 70% 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 ..... 70% of the Eligible Charge or Usual & Customary Fee

Emergency Care

Emergency Accident Care and Emergency Medical Care (Hospital and Physician) ..... 70% of the Eligible Charge or Usual & Customary Fee, no Deductible

Benefit Maximums for

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

Outpatient Mental Illness Treatment and
Outpatient Substance Abuse Rehabilitation Treatment

Hospital and Physician Payment Level	50% of the Eligible Charge or Usual & Customary Fee
Calendar Year Maximum	$1,000

Inpatient Mental Illness Treatment and
Inpatient Substance Abuse Rehabilitation Treatment

In a **PPO** Hospital	70% of the Eligible Charge for the first 10 days; 50% thereafter
In a **Non-PPO** Hospital	60% of the Eligible Charge for the first 10 days; 50% thereafter
In a **Non-Plan** Hospital	50% of the Eligible Charge
Physician Services	70% of the Usual and Customary Fee
Calendar Year Maximum	$10,000
Combined Inpatient/Outpatient Lifetime Maximum	$25,000

DEFINITIONS SECTION

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

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

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

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

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

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.

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

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

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

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

CLAIM CHARGE.....means the amount which appears on a Claim as the Provider's charge for service rendered to you, without adjustment or reduction and regardless of any separate financial arrangement between Blue Cross and Blue Shield and a particular Provider. (See provisions of this Policy regarding "Blue Cross and Blue Shield's Separate Financial Arrangements with Providers.")

CLAIM PAYMENT.....means the benefit payment calculated by Blue Cross and Blue Shield, after submission of a Claim, in accordance with the benefits described in this Policy. All Claim Payments will be calculated on the basis of the Eligible Charge for Covered Services rendered to you, regardless of any separate financial arrangement between Blue Cross and Blue Shield and a particular Provider. (See provisions of this Policy regarding "Blue Cross and Blue Shield's Separate Financial Arrangements with Providers.")

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

EMERGENCY MEDICAL CARE.....means the initial Outpatient treatment, including related Diagnostic Service, of the sudden and unexpected onset of a medical condition which has such severe symptoms that the absence of immediate medical attention could result in serious and permanent medical consequences. Examples of these types of symptoms are severe chest pains, convulsions or persistent severe abdominal pains.

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

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

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

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

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

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

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

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

INVESTIGATIONAL or INVESTIGATIONAL SERVICES AND SUPPLIES.....means procedures, drugs, devices, services and/or supplies which (1) are provided or performed in special settings for re-

search 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, combinations of drugs and/or devices, are not finally approved by the Federal Drug Administration at the time used or administered to you.

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

MATERNITY SERVICE.....means the services rendered for normal pregnancy. A normal pregnancy means an intrauterine pregnancy which, through vaginal delivery, results in an infant, who weighs five pounds or more and who has no signs of post-maturity. Precautionary Medical Care due to adverse maternal age, poor prior obstetrical history, Pre-Existing Conditions, suspected genetic abnormality, all of which make complications more likely, will be considered as part of normal pregnancy.

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

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

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

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

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

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

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

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

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

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.

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

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

PPO HOSPITAL.....see definition of HOSPITAL

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

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

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

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

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

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

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

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

A "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.

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

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

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

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

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

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

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

SKILLED NURSING FACILITY.....means an institution or a distinct part of an institution which has a transfer agreement with one or more Hospitals and which is primarily engaged in providing comprehensive post-acute Hospital and rehabilitative Inpatient care and is duly licensed by the appropriate govern-

mental authority to provide such services. It does not mean institutions which provide only minimal care, Custodial Care Services, ambulatory or part-time care services or institutions which primarily provide for the care and treatment of Mental Illness, pulmonary tuberculosis or Substance Abuse.

A "Plan Skilled Nursing Facility" means a Skilled Nursing Facility which has a written agreement with Blue Cross and Blue Shield 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 but has been certified in accordance with guidelines established by Medicare.

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

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

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

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

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

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

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

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

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

USUAL AND CUSTOMARY FEE.....means the fee as reasonably determined by Blue Cross and Blue Shield, which is based on the fee which the Physician, Dentist, Podiatrist, Psychologist, Clinical Social Worker, Chiropractor or Optometrist who renders the particular service usually charges his patients for the same service and the fee which is within the range of usual fees other Physicians, Dentists, Podiatrists,

Psychologists, Clinical Social Worker, Chiropractors or Optometrists of similar training and experience in a similar geographic area charge their patients for the same service, under similar or comparable circumstances. However, if Blue Cross and Blue Shield reasonably determines that the Usual and Customary Fee for a particular service is unreasonable because of extenuating or unusual circumstances, the Usual and Customary Fee for such service shall mean the reasonable fee as reasonably determined by Blue Cross and Blue Shield.

COVERAGE AND PREMIUM INFORMATION

YOUR APPLICATION FOR COVERAGE

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

YOUR BLUE CROSS AND BLUE SHIELD ID CARD

You will receive a Blue Cross and Blue Shield identification card. This card will tell you the date that your coverage under this program begins (that is, your Coverage Date) and your Blue Cross and Blue Shield identification number. This information will be very important to you in obtaining your benefits.

INDIVIDUAL COVERAGE

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

FAMILY COVERAGE

If you have Family Coverage, your health care expenses and those of your enrolled spouse and your (or your spouse's) enrolled unmarried children who are under age 19 will be covered. Enrolled unmarried children who are full-time students will be covered up to age 25. Coverage for unmarried children will end on the 19th or 25th birthday. Coverage for children who marry 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 us 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, either because of marriage or the birth or adoption of a child, if you apply for the change within 31 days of the marriage, birth, adoption or court order. Your Family Coverage or the coverage for your additional dependents will then be effective from the date of the marriage, birth, adoption or court order. You can get an application from any Blue Cross and Blue Shield office.

If you do not make application for Family Coverage or to add dependents within the allotted time, you can make application at any time upon submission to and approval by Blue Cross and Blue Shield of Evidence of Insurability. If approved by Blue Cross and Blue Shield, the change will be effective 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 COVERAGE CHANGES

Medicare Eligibility

Coverage for any person covered under this Policy who becomes eligible for Medicare will automatically terminate at the beginning of the month in which such person reaches age 65 or otherwise becomes eligible for Medicare. However, Blue Cross and Blue Shield will, at that time, offer such person a new Policy containing provisions which are generally offered to persons in that age or eligibility classification. The established charges for the new coverage 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, and within 60 days following the entry of the divorce decree, a new Policy of the same type. Your dependent children may either continue coverage under your Policy, become covered under your spouse's new Policy or change to separate Individual Coverage Policies (but only if you and your spouse have both elected Individual Coverage). Any Pre-Existing Conditions Waiting Period applicable to the new Policy(s) shall be considered as being met to the extent that such waiting period was satisfied under this Policy.

In the Event of your Death

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

Covered Dependent Children

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

PAYMENT OF PREMIUMS

1. Your first premium is due on your Coverage Date. Later premiums are due and payable on the due date, which is the date shown on your billing statement.
2. The initial premium for Individual Coverage is based on your age at the time your coverage commences and the initial premium for Family Coverage is based on your age, your spouse's age and any eligible dependent children at the time coverage is applied for.
3. Blue Cross and Blue Shield may establish a new premium for any of the benefits of this Policy on any of the following dates or occurrences:
   a. any premium due date, provided Blue Cross and Blue Shield notifies you of the new premium amount at least 30 days in advance of such premium due date;
   b. whenever the benefits of this Policy are increased, which may occur whenever required by law or whenever Blue Cross and Blue Shield gives notice of an increase in benefits;
   c. whenever you or your spouse attain an age which results in a change in the premium amount due for that age category of coverage;
   d. whenever the number of persons covered under this Policy is changed.

4. If the ages upon which the premium is based have been misstated, an amount which will provide Blue Cross and Blue Shield with the correct premium from your Coverage Date shall be due and payable upon billing or receipt from Blue Cross and Blue Shield.
5. If you fail to pay premiums to Blue Cross and Blue Shield within 31 days of the premium due date, this Policy will automatically terminate. Benefits will not be provided for expenses incurred during this 31-day grace period or thereafter unless the premiums are paid within this period.

REINSTATEMENT

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

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

EXTENSION OF BENEFITS IN CASE OF TERMINATION

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

and Blue Shield Physician. Should the Blue Cross and Blue Shield Physician concur that the Inpatient care or continued Inpatient care is not Medically Necessary, written notification of the decision will be provided to you, your attending Physician, and the Hospital, and will specify the dates for which benefits will not be provided. For further details regarding Medically Necessary care and other exclusions from coverage under this Policy, refer to the Exclusions Section.

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 determination of Medically Necessary care is limited to merely whether a proposed admission or continued hospitalization meets the criteria for Medically Necessary care under this Policy.

In the event that the criteria for Medically Necessary care are not met for all or any portion of an Inpatient hospitalization, Blue Cross and Blue Shield will not be responsible for any related Hospital charge incurred.

Blue Cross and Blue Shield 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 date; and
4. a preliminary diagnosis or reason for the admission.

The MSA will review the medical information provided. You or your admitting Physician may receive a verbal recommendation from the MSA to have the service performed on an Outpatient basis or to obtain an additional opinion regarding the service that has been recommended by your Physician.

ADDITIONAL OPINION

In some instances, an additional medical/surgical opinion may be required after you contact the MSA. If this occurs, the MSA will furnish you with the names of Physicians with whom Blue Cross and Blue Shield has an agreement to render an additional opinion. Benefits for the additional opinion, when arranged by the MSA, will be provided at 100% of the Usual and Customary Fee without application of any Deductibles which might otherwise be applicable under this Policy.

Benefits are also available for any Diagnostic Service required by the Physician. The Physician may request that you provide the results of any Diagnostic Services previously performed. If the need for planned services is not resolved by the additional opinion, benefits will be provided for a third opinion at your request.

Regardless of the results of the additional opinion, if you elect to have the initially planned service, you may do so without a reduction of the benefits provided under this Policy. However, Blue Cross and Blue Shield shall not, in any event, be liable for any act or omission of any Physician or any agent or employee of the Physician, including, but not limited to, a failure or refusal to render services to you or for not providing you with the name of a particular Physician for the additional opinion.

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 most instances, the resolution of the appeal process will not be completed until the admission has occurred or the assigned length of stay has elapsed. If you disagree with a decision after claim processing has taken place, the decision may be appealed by following the procedures for claim review in this Policy. 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.

NON-COMPLIANCE WITH RECOMMENDATIONS OF THE MSA

Should you fail to notify the MSA as required or fail to comply with the recommendations of the MSA, you will be responsible for the first $1,000 of the Hospital charges once the admission has occurred. This amount is in addition to any Deductibles and/or co-payments which may apply to Inpatient Hospital admissions.

INDIVIDUAL BENEFITS MANAGEMENT PROGRAM (IBMP)

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

Alternative benefits will be provided only when and for as long as Blue Cross and Blue Shield determines that the alternative services are Medically Necessary and cost-effective. The total benefits provided for alternative services shall not exceed the total benefits to which you would otherwise be entitled under this Policy in the absence of alternative benefits.

You may send a written request to Blue Cross and Blue Shield to be considered for coverage under this alternative benefit provision. However, the final determination as to eligibility for these benefits will be made by Blue Cross and Blue Shield, and only after approval of the alternative treatment plan by you and your Physician.

Each case will be decided by applying Blue Cross and Blue Shield's criteria to the facts of the case. Blue Cross and Blue Shield's decision to provide alternative benefits in one instance does not obligate it to provide the same or similar benefits for any person in any other instance, nor shall it be construed as a waiver of Blue Cross and Blue Shield's right to administer the Policy in all other respects in strict accordance with its express terms.

HOSPITAL BENEFIT SECTION

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

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

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

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

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

INPATIENT COVERED SERVICES

Inpatient Hospital Care

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

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

Pre-Admission Testing

This is a program in which benefits are provided for pre-operative 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.

Special Programs

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

1. **Partial Hospitalization Psychiatric Treatment**—To be eligible for this program, your treatment must follow a covered Inpatient Hospital stay and you must be admitted to this program within three days of discharge from that stay. Your treatment is considered a continuation of that stay.
2. **Coordinated Home Care**—Benefits will be provided for services received in a Coordinated Home Care Program provided that these services would have been available to you as an Inpatient in a Hospital and you are admitted to the program within 72 hours of discharge as an Inpatient in a Hospital or Skilled Nursing Facility.

BENEFIT PAYMENT FOR INPATIENT COVERED SERVICES

After you have met your benefit program Deductible, benefits will be provided at 70% of the Hospital's Eligible Charge when you receive Inpatient Covered Services in a PPO Hospital or in a Plan Program of a PPO Hospital or in any Hospital located outside of the state of Illinois.

When you receive Inpatient Covered Services in a Non-PPO Hospital or in a Plan Program of a Non-PPO Hospital, benefits will be provided at 60% of the Eligible Charge, after you have met your benefit program Deductible and a separate $300 Inpatient Non-PPO Hospital Deductible.

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

Emergency Admissions

If you must be hospitalized in a Non-Plan Hospital immediately following Emergency Accident Care or Emergency Medical Care, benefits will be provided at the 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 the services from a Hospital (or other specified provider) as an Outpatient:

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

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

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

BENEFIT PAYMENT FOR OUTPATIENT COVERED SERVICES

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

- 70% of the Eligible Charge for Outpatient Covered Services received in a PPO Hospital, Plan Coordinated Home Care Program, Plan Ambulatory Surgical Facility or Plan Dialysis Facility or in any Hospital, Ambulatory Surgical Facility or Dialysis Facility located outside of the state of Illinois.
- 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 received in a Non-Plan Hospital, Non-Plan Ambulatory Surgical Facility or Non-Plan Dialysis Facility.

Benefits for Emergency Accident Care and Emergency Medical Care 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.

PHYSICIAN BENEFIT SECTION

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

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

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

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

COVERED SERVICES

Surgery

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

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

The following services are also part of your surgical benefits:

1. Sterilization Procedures (even if they are elective).
2. Anesthesia—If administered at the same time as a covered surgical procedure by a Physician other than the operating surgeon or by a CRNA.
3. 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.

Additional Surgical Opinion

Your coverage includes benefits for an additional surgical opinion following a recommendation for elective Surgery. In order to obtain an additional surgical opinion, you must contact the Additional Surgical Opinion Referral Center before you enter a Hospital or Ambulatory Surgical Facility for elective Surgery. The Center will furnish you with the names of three Physicians. You may select one Physician for the consultation from the names furnished or you may select any other Physician who has an agreement with Blue Cross and Blue Shield to render such services. At your request, benefits will be provided for an additional consultation when the need for Surgery, in your opinion, is not resolved by the first arranged consultation.

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

Medical Care
Benefits are available for Medical Care visits when:

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

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

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

Mammograms

Shock Therapy Treatments

Radiation Therapy Treatments

Chemotherapy

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

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

Emergency Medical Care

BENEFIT PAYMENT FOR PHYSICIAN SERVICES
When you receive any of the Covered Services described in this Physician Benefits Section (except as noted below), 70% of the Usual and Customary Fee will be paid after you have met your benefit program Deductible. Benefits for Emergency Accident Care and Emergency Medical Care are not subject to a Deductible.

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

OTHER COVERED SERVICES

COVERED SERVICES

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

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

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

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

ation. Inpatient Speech Therapy benefits will be provided only if Speech Therapy is not the only reason for admission. Benefits for Outpatient Speech Therapy will be limited to a maximum of $3,000 per calendar year.

- Physical Therapy—Benefits will be provided for Physical Therapy when these services are rendered by a Physician or by a registered professional physical therapist under the supervision of a Physician. This therapy must be furnished under a written plan established by a Physician and regularly reviewed by the therapist and the Physician. The plan must be established before treatment is begun and must relate to the type, amount, frequency and duration of therapy and indicate the diagnoses and anticipated goals. Benefits for Outpatient Physical Therapy will be limited to a maximum of $3,000 per calendar year.
- Occupational Therapy—Benefits will be provided for Occupational Therapy when these services are rendered by a Physician or by a registered occupational therapist under the supervision of a Physician. This therapy must be furnished under a written plan established by a Physician and regularly reviewed by the therapist and the Physician. The plan must be established before treatment is begun and must relate to the type, amount, frequency and duration of therapy and indicate the diagnosis and anticipated goals. Benefits for Outpatient Occupational Therapy will be limited to a maximum of $3,000 per calendar year.
- Cardiac Rehabilitation Services—Benefits will be provided for cardiac rehabilitation services only in Blue Cross and Blue Shield approved programs when these services are rendered to you within a six-month period following an eligible Inpatient Hospital admission for either myocardial infarction, coronary artery bypass Surgery, or percutaneous transluminal coronary angioplasty.
- Outpatient drugs and medicines—Benefits will be provided for all drugs and medicines (except contraceptive drugs or drugs used for cosmetic purposes including, but not limited to, Retin-A/Tretinoin and Minoxidill/Rogaine) which require by law a written prescription and which are dispensed by a Pharmacy or Physician. In addition, your coverage includes benefits for insulin even though a prescription may not be required by law.

BENEFIT PAYMENT FOR OTHER COVERED SERVICES

After you have met your benefit program Deductible, benefits will be provided at 70% of the Eligible Charge or Usual and Customary Fee for any of the Covered Services described in this section.

SPECIAL CONDITIONS

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

HUMAN ORGAN TRANSPLANTS

Benefits for all of the Covered Services previously described in this Policy are available for human organ transplants. Benefits will be provided only for cornea, kidney, bone marrow, heart valve, muscular-skeletal, parathyroid, heart, heart/lung, lung, liver, pancreas and pancreas/kidney human organ or tissue transplants. Benefits are available to both the recipient and donor of a covered transplant as follows:

- If both the donor and recipient have Blue Cross and Blue Shield coverage each will have their benefits paid by their own Blue Cross and Blue Shield program.
- If you are the recipient of the transplant, and the donor for the transplant has no coverage from any other source, the benefits under this Policy will be provided for both you and the donor. In this case, payments made for the donor will be charged against your benefits.
- If you are the donor for the transplant and no coverage is available to you from any other source, the benefits under this Policy will be provided for you. However, no benefits will be provided for the recipient.

Your 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 the transportation of the donor organ to the location of the transplant Surgery. Benefits will be limited to the transportation of the donor organ in the United States or Canada.

Whenever a heart, heart/lung, lung, liver, pancreas, or pancreas/kidney transplant is recommended by your Physician, you must contact Blue Cross and Blue Shield by telephone before your transplant Surgery has been scheduled. Blue Cross and Blue Shield will furnish you with the names of Hospitals which have Blue Cross and Blue Shield approved 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 Transplants Coverage Program.

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

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

SKILLED NURSING FACILITY CARE

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

Covered Services in a Skilled Nursing Facility

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

After you have met your benefit program Deductible, benefits will be provided at 70% of the Eligible Charge for Covered Services rendered in a Plan Skilled Nursing Facility or in a Non-Plan Skilled Nursing Facility located outside the state of Illinois and at 50% of the Eligible Charge for Covered Services rendered in a Non-Plan Skilled Nursing Facility in Illinois.

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

SUBSTANCE ABUSE REHABILITATION TREATMENT AND MENTAL ILLNESS TREATMENT

Substance Abuse Rehabilitation Treatment

Benefits for all of the Covered Services previously described in this Policy are available for the rehabilitative treatment of Substance Abuse. In addition, benefits will be provided if these Covered Services are rendered by a Substance Abuse Treatment Facility. However, benefits will only be provided for Substance Abuse Rehabilitation Treatment rendered in programs which have been approved in writing by Blue Cross and Blue Shield or for services rendered in a Plan Substance Abuse Treatment Facility, except for the treatment of alcoholism. Benefits will be provided for the Inpatient treatment of alcoholism in a non-approved program or a Non-Plan facility at the same payment level as Non-Plan Hospital Covered Services. Benefits for the Outpatient treatment of alcoholism are described below.

Mental Illness Treatment

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

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

Benefit Payment for Outpatient Treatment

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

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

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

Benefit Payment for Inpatient Treatment

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

- for Inpatient treatment of Mental Illness in a PPO Hospital or in any Hospital located outside of the state of Illinois, benefits will be provided at 70% of the Eligible Charge for the first 10 days of each admission and at 50% of the Eligible Charge thereafter.
- for Inpatient Substance Abuse Rehabilitation Treatment in a Blue Cross and Blue Shield-approved program of a PPO Hospital or in a Plan Substance Abuse Treatment Facility, benefits will be provided at 70% of the Eligible Charge for the first 10 days of each admission and at 50% of the Eligible Charge thereafter.
- for Inpatient treatment of Mental Illness in a Non-PPO Hospital, benefits will be provided at 60% of the Eligible Charge for the first 10 days of each admission and at 50% of the Eligible Charge thereafter.

- for Inpatient Substance Abuse Rehabilitation Treatment in a Blue Cross and Blue Shield-approved program of a Non-PPO Hospital, benefits will be provided at 60% of the Eligible Charge for the first 10 days of each admission and at 50% of the Eligible Charge thereafter.
- for Inpatient treatment of Mental Illness in a Non-Plan Hospital and for Inpatient treatment of alcoholism in a Non-Plan Hospital or Non-Plan Substance Abuse Treatment Facility, benefits will be provided at 50% of the Eligible Charge.
- for Covered Services rendered by a Physician or other professional Provider for the Inpatient treatment of Mental Illness or Inpatient Substance Abuse Rehabilitation Treatment, benefits will be provided at 70% of the Usual and Customary Fee.

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

Inpatient/Outpatient Lifetime Maximum

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

COMPLICATIONS OF PREGNANCY

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

TEMPOROMANDIBULAR JOINT DYSFUNCTION AND RELATED DISORDERS

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

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

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 a continued stay in a Hospital.
- Hospitalization or admission to a Skilled Nursing Facility, nursing home or other facility for the primary purposes of providing Custodial Care Service, convalescent care, rest cures or domiciliary care to the patient.
- Hospitalization or admission to a Skilled Nursing Facility for the convenience of the patient or Physician or because care in the home is not available or is unsuitable.
- The use of skilled or private duty nurses to assist in daily living activities, routine supportive care or to provide services for the convenience of the patient and/or his family members.

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

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

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

If your Claim for benefits is denied on the basis that the services or supplies were not Medically Necessary, and you disagree with Blue Cross and Blue Shield's decision, your policy provides for an appeal of that decision. You must exercise your right to 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
P.O. Box 2401
Chicago, Illinois 60690

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

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

- Services or supplies that are not specifically mentioned in this Policy.
- Services or supplies for which benefits are available under any Worker's Compensation Law or other similar laws, except where not required by law.
- Services or supplies that are furnished to you by the local, state or federal government and for any services or supplies to the extent payment or benefits are provided or available from the local, state or federal government (for example, Medicare) whether or not that payment or benefits is received, except as otherwise provided by law.
- Services and supplies for any illness or injury occurring on or after your Coverage Date as a result of war or an act of war.
- Services or supplies that do not meet accepted standards of medical or dental practice; and Investigational Services and Supplies including all related services and supplies.
- Custodial Care Service.
- Routine physical examinations.
- Services or supplies received during an Inpatient stay when the stay is primarily related to behavioral, social maladjustment, lack of discipline or other antisocial actions which are not specifically the result of Mental Illness.
- Cosmetic Surgery and related services and supplies, except for the correction of congenital deformities or for conditions resulting from accidental injuries, scars, tumors or diseases.
- Services or supplies received from a dental or medical department or clinic maintained by an employer, labor union or other similar person or group.
- Services or supplies for which you are not required to make payment or would have no legal obligation to pay if you did not have this or similar coverage.
- Charges for failure to keep a scheduled visit or charges for completion of a Claim form.
- Personal hygiene, comfort or convenience items commonly used for other than medical purposes, such as air conditioners, humidifiers, physical fitness equipment, televisions and telephones.
- Special braces, splints, specialized equipment, appliances, ambulatory apparatus, battery or atomically controlled implants, except as specifically mentioned in this Policy.
- Blood derivatives which are not classified as drugs in the official formularies.
- Eyeglasses, contact lenses or cataract lenses and the examination for prescribing or fitting of glasses or contact lenses or for determining the refractive state of the eye, except as specifically mentioned in this Policy.
- Treatment of flat foot conditions and the prescription of supportive devices for such conditions and the treatment of subluxations of the foot or routine foot care.
- Immunizations.
- Maintenance Occupational Therapy, Maintenance Physical Therapy, and Maintenance Speech Therapy.
- Speech Therapy when rendered for the treatment of psychosocial speech delay, behavioral problems (including impulsive behavior and impulsivity syndrome), attention disorder, conceptual handicap

or mental retardation.

- Hearing aids or examinations for the prescription or fitting of hearing aids.
- Diagnostic Service as part of routine physical examinations or check-ups, premarital examinations, determination of the refractive errors of the eyes, auditory problems, surveys, casefinding, research studies, screening, or similar procedures and studies, or tests which are Investigational.
- Procurement or use of prosthetic devices, special appliances and surgical implants which are for cosmetic purposes, the comfort and convenience of the patient, or unrelated to the treatment of a disease or injury.
- Services and supplies rendered or provided for human organ or tissue transplants other than cornea, kidney, bone marrow, heart valve, muscular-skeletal, parathyroid, heart, heart/lung, lung, liver, pancreas or pancreas/kidney human organ or tissue transplants, unless otherwise specified in this Policy.
- Services and supplies rendered or provided for the diagnosis and/or treatment of infertility including, but not limited to, Hospital services, Medical Care, therapeutic injections, fertility and other drugs, Surgery, artificial insemination and all forms of in-vitro fertilization.
- Maternity Service, including related services and supplies.

HOW TO FILE A CLAIM

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

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

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

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

   Blue Cross and Blue Shield
   233 North Michigan Avenue
   Chicago, Illinois 60601

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

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

CLAIM REVIEW PROCEDURES

Blue Cross and Blue Shield will pay all Claims within 30 days of receipt of all information required to process a Claim. In the event that Blue Cross and Blue Shield does not process your Claim within this 30-day period, you shall be entitled to interest, at the rate of 9% per year, from the 30th day after the receipt of all Claim information until the date payment is actually made. However, interest payment will not be made if the 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
P.O. Box 2401
Chicago, Illinois 60690

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

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

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

DEPARTMENT OF INSURANCE ADDRESS

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

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

or

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

GENERAL PROVISIONS

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

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

2. PAYMENT OF CLAIMS AND ASSIGNMENT OF BENEFITS

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

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

c. Neither this Policy nor a Covered Person's claim for payment of benefits under this Policy are assignable in whole or in part to any person or entity at any time. Coverage under this Policy is expressly non-assignable and non-transferable and will be forfeited if you attempt to assign or transfer coverage or aid or attempt to aid any other person in fraudulently obtaining coverage.

3. YOUR PROVIDER RELATIONSHIPS

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

b. Blue Cross and Blue Shield does not itself undertake to furnish health care services, but solely to make payments to Providers for the Covered 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 at its offices at 233 North Michigan Avenue, Chicago, Illinois 60601. Any information or notice which Blue Cross and Blue Shield furnishes to you must be in writing and sent to you at your address as it appears on Blue Cross and Blue Shield records.

6. 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.

7. DEATH OF THE INSURED-REFUND OF PREMIUMS

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

8. 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.

9. APPLICABLE LAW

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

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:

1. to immediately reimburse Blue Cross and Blue Shield for any damages collected, whether by action at law, settlement or otherwise, to the extent that Blue Cross and Blue Shield has provided benefits to you or your covered dependents; and
2. that Blue Cross and Blue Shield will have a lien to the extent of benefits provided. Such lien may be filed with the person whose act caused the injury, the person's agent or a court having jurisdiction in the matter.

It is your responsibility to furnish any information, assistance or provide any documents that Blue Cross and Blue Shield may request in order to obtain its rights under this provision.

Blue Cross
Blue Shield
of Illinois

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

CONVERSION PPO PLAN 500 C2

BENEFITS SUMMARY

	PPO PLAN 500 C2 Participating Provider Coverage	PPO PLAN 500 C2 Non-Participating Provider Coverage
LIFETIME COVERAGE	$1,000,000	$1,000,000
INPATIENT AND OUTPATIENT HOSPITAL SERVICES	70%	60%
MEDICAL/SURGICAL SERVICES (inpatient and outpatient)	70%	70%
DIAGNOSTIC SERVICES Includes x-rays, lab tests, EKGs, ECGs, pathology services, pulmonary function studies, radioisotope tests, and electromyograms.		
Hospital	70%	60%
Physician	70%	70%
OTHER COVERED SERVICES Services of a registered physical, occupational, or speech therapist ($3,000 per calendar year for each); chiropractic services given by a physician or chiropractor ($1,000 per calendar year); ambulance service; physician office and/or home visits; blood plasma; private duty nursing services ($1,000 per month maximum); leg, arm, back and neck braces; surgical dressing; casts and splints; prescription drugs, radiation and chemotherapies.	70%	70%
OUTPATIENT EMERGENCY CARE For both hospital and physician (deductible does not apply).	70%	70%
ADDITIONAL SURGICAL OPINION PROGRAM Following a recommendation for elective surgery, provides additional consultation and related diagnostic service by a physician (deductible does not apply).	100%	100%
PSYCHIATRIC AND SUBSTANCE ABUSE CARE Maximum lifetime benefit of $25,000		
Inpatient care limited to $10,000 per calendar year — First 10 days	70%	60%
Thereafter	50%	50%
Outpatient care limited to $1,000 per calendar year	50%	50%

All percentages shown apply to either "Usual and Customary" fees and/or Eligible Charges

BASIC PROVISIONS

DEDUCTIBLE Per individual per calendar year.	$500	$500
FAMILY DEDUCTIBLE A maximum of three individual deductible amounts per family.	$1500	$1500
HOSPITAL ADMISSION DEDUCTIBLE Per admission per individual in addition to calendar year deductible.	$0	$300

MEDICAL SERVICES ADVISORY Notification required prior to all elective admissions. Emergency and obstetric admission notification required within two working days of admission. If individual elects not to notify MSA®, or follow advice given as explained in the policy, hospital benefits are reduced by $1,000.

CONVERSION TERMS Application must be made within 31 days from your group coverage cancellation date. Benefits for this coverage will be made retroactive to the group coverage cancellation date. There will be no lapse of coverage.

PRE-EXISTING CONDITIONS WAITING PERIOD* All waiting periods satisfied with your group coverage will be credited to your new Direct Pay Coverage.

DEPENDENT ELIGIBILITY To age 19, if unmarried.
To age 25, if unmarried, full-time student.

*Pre-existing condition is a health condition for which medical advice or treatment was recommended by a doctor during the 12 months before your coverage effective date or for which symptoms existed which would cause an ordinarily prudent person to seek diagnosis or treatment.
MSA® is a registered service mark of Health Care Service Corporation, A Mutual Legal Reserve Company.

THIS PLAN DOES NOT COVER NORMAL MATERNITY BENEFITS.

This sheet includes only highlights of the various programs.
Your policy will specifically describe the applicable terms, conditions, limitations and exclusions of coverage.

OB2179 Rev. 9/02

Exclusions and Limitations Under Your Blue Cross and Blue Shield Coverage

Services and supplies for or related to the following are not covered: those determined by blue Cross to be "not medically necessary;" not specifically mentioned in the Policy; provided or available under Worker's Compensation or similar laws (except where not required by law); furnished or reimbursable by local, state, or federal government; illness or injury caused as a result of war or an act of war; those that do not meet accepted standards of medical practice; Investigational services and supplies; Custodial Care Services; routine physical examinations, and immunizations; inpatient stay when the stay is primarily related to behavioral social-maladjustment, lack of discipline or other anti-social actions which are not specially the result of Mental Illness; those received from a dental or medical department or clinic maintained by an employer, labor union or other similar person or group; those for which you are not required to make payment; charges for failure to keep a scheduled visit or complete a claim form; personal hygiene, comfort or convenience items; blood derivatives which are not classified as drugs in the official formularies; eyeglasses, contact lenses or cataract lenses and the examination for prescribing or fitting of glasses or contact lenses; flat foot conditions; subluxations of the foot or routine foot care; Maintenance Occupational, Physical and Speech Therapies; Speech Therapy when given for the treatment of psychosocial speech delay, behavioral problems (including impulsive behavior and impulsivity syndrome), attention disorder, conceptual handicap or mental retardations; hearing aids or examinations for the prescription or fitting of hearing aids; diagnostic services as part of routine physical examinations or tests which are Investigational; procurement or use of prosthetic devices, special appliance and surgical implants which are for cosmetic purposes, the comfort and convenience of the patient, or unrelated to the treatment of a disease or injury; cosmetic surgery; human organ transplants except as specified in the Policy; diagnosis and/or treatment of infertility including, but not limited to, Hospital Services Medical Care, therapeutic injections, fertility and other drugs, surgery, artificial insemination and all forms of in-vitro fertilization; **Maternity Service, including related services and supplies, (complications are covered as any other illness).**
For complete details on Exclusions and other limitations of this program, please review your Policy.

Premiums and Renewability

Unless we terminate all DB-24 plans like this, and as long as premiums are paid, you and your spouse (if insured) may renew your coverage until age 65 or Medicare eligibility, whichever is earlier. This policy will not be renewed following the insured's sixty-fifth (65th) birthday. The insured has the right to convert this policy to a current Medicare Supplement Plan, which is then being issued by Blue Cross and Blue Shield of Illinois, with immediate benefits subject to no additional waiting period.

For dependent children, coverage under this policy will cease on the dependent's nineteenth (19th) birthday or twenty-fifth (25th) birthday if unmarried and a full-time student. The dependent will have the right to convert this coverage to an individual plan which is then being issued by Blue Cross and Blue Shield of Illinois, with immediate benefits, subject to no additional waiting period.

Blue Cross and Blue Shield of Illinois reserves the right to adjust premium rates for all Policies like this, with a general rate increase or when a change in age occurs.

We will give you at least thirty (30) days notice prior to any coverage or premium changes.

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
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

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

DEFINITIONS SECTION

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Attest:

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

Deborah Dorman-Rodriguez
Secretary

Patricia A. Heminway Hall
President

RIDER TO THE POLICY

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

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

A. Policy Year

The following is added to your Policy:

POLICY YEAR

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

B. Effective Date

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

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

C. Dependent Coverage

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

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

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

The following is added to your Policy:

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

E. Preexisting Conditions Waiting Period

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

F. Emergency Services

1. The following definition is added to your Policy:

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

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

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

G. Rescissions

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

RESCISSION OF COVERAGE

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

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

H. Preventive Care Services

The following provision is added to your Policy:

PREVENTIVE CARE SERVICES

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

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

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

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

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

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

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

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

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

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

I. Lifetime Maximums

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

J. Benefit Maximums

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

- Occupational Therapy
- Physical Therapy
- Private Duty Nursing Service

K. Internal Claims Determinations and Appeals Process

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

INITIAL CLAIMS DETERMINATIONS

Blue Cross and Blue Shield will usually process all Claims within 30 days of receipt of all information required to process a Claim. In the event that Blue Cross and Blue Shield does not process a Claim within this 30-day period, you or the valid assignee shall be entitled to interest at the rate of 9% per year, from the 30th day after the receipt of all Claim information until the date payment is actually made. However, interest payment will not be made if the amount is $1.00 or less. Blue Cross and Blue Shield will usually notify you, your valid assignee or your authorized representative, when all information required to process a Claim within 30 days of the Claim's receipt has not been received. (For information regarding assigning benefits, see "Payment of Claims and Assignment of Benefits" provision in the GENERAL PROVISIONS section of your Policy.) If you fail to follow the procedures for filing a pre-service claim (as defined below), you will be notified within 5 days (or within 24 hours in the case of a failure

regarding an urgent care/expedited clinical claim [as defined below]). Notification may be oral unless the claimant requests written notification.

If a Claim Is Denied or Not Paid in Full

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

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

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

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

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

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

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

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

   a. The reasons for denial;

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

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

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

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

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

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

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

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

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

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

INQUIRIES AND COMPLAINTS

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

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

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

- Claims
- Quality of care

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

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

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

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

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

CLAIM APPEAL PROCEDURES - DEFINITIONS

An appeal of an Adverse Benefit Determination may be filed by you or a person authorized to act on your behalf. In some circumstances, a health care provider may appeal on his/her own behalf. Your designation of a representative must be in writing as it is necessary to protect against disclosure of information about you except to your authorized representative. To obtain

an Authorized Representative Form, you or your representative may call Blue Cross and Blue Shield at the number on the back of your ID card.

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

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

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

CLAIM APPEAL PROCEDURES

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

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

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

In support of your Claim review, you have the option of presenting evidence and testimony to Blue Cross and Blue Shield, by phone or in person at a location of Blue Cross and Blue Shield's choice. You and your authorized representative may ask to review your file and any relevant documents and may submit written issues, comments and additional medical information within 180 days after you receive notice of an Adverse Benefit Determination or at any time during the Claim review process.

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

Urgent Care/Expedited Clinical Appeals

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

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

Other Appeals

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

If You Need Assistance

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

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

If you need assistance with the internal claims and appeals or the external review processes that are described below, you may contact the health insurance consumer assistance office or ombudsman. You may contact the Illinois ombudsman program at1-877-527-9431, or call the number on the back of your ID card for contact information.

Notice of Appeal Determination

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

The written notice will include:

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

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

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

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

The Illinois Department of Insurance can be contacted at:

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

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

INDEPENDENT EXTERNAL REVIEW

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

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

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

1. **Standard External Review**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The written notice will include:

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

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

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

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

2. Expedited External Review

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

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

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

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

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

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

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

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

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

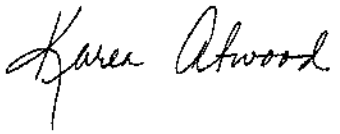
Within 48 hours after the date of providing the notice, the assigned IRO shall provide written confirmation of the decision to you, Blue Cross and Blue Shield and, if applicable, your authorized representative, including all the information outlined under the standard process above.

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

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

Attest:

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



Karen Atwood
President

RIDER TO THE POLICY

Effective Date: 10/01/2010

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

EXCLUSIONS—WHAT IS NOT COVERED

The hearing aid exclusion is revised to read as follows:

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

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

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

Jeffrey R. Tikkanen
President, Retail Markets

RIDER TO THE POLICY TO IMPLEMENT
ILLINOIS WELLNESS COVERAGE

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

The changes below are effective June 1, 2010.

GENERAL PROVISIONS

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

VALUE BASED DESIGN PROGRAMS

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

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

Attest:

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

Karen Atwood

Karen Atwood
President

BlueCross BlueShield
of Illinois

Notice of Information Practices

HEALTH CARE SERVICE CORPORATION
A MUTUAL LEGAL RESERVE COMPANY

This description of the Information Practices of Health Care Service Corporation ("HCSC"), a Mutual Legal Reserve Company, is provided to you in accordance with the requirements of the Illinois Insurance Information and Privacy Protection Law.

Collection of Information

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

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

Circumstances of Disclosures by HCSC

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

- We might use an unaffiliated organization or person to perform a professional, business or insurance function for us. If, for example, we hired an independent organization to assist in the administration of a group insurance plan of which you are a participant, information relating to your insurance coverage would be disclosed to that organization in order for it to adequately perform its function. This would also be the case with respect to any organization or person which performs a professional, business or insurance function for us.

- We may disclose information concerning your coverage to HCSC agents and brokers in order to provide you with adequate service, including the updating and improvement of your insurance program.

- We may disclose information to other insurance institutions, agents, insurance-support organizations or self-insurers, which is necessary (a) to prevent criminal activity, fraud, material misrepresentation or material non-disclosure in connection with insurance transactions, or (b) for either HCSC or such company to perform its function in connection with an insurance transaction involving you or a member of your family insured under your coverage. For example, if you are a participant in an HCSC group health insurance plan, and if you, your spouse or dependents are insured under other group plans, the companies involved may be required to share claims information pursuant to coordination of benefits provisions in their respective policies. The object, of course, is to make sure that you receive total benefits from all companies no greater in amount than the cost of health care received.

- We may disclose information to the Illinois Insurance regulatory authority in connection with its regulation of our business.

- We may disclose information to a law enforcement or governmental authority to protect our interests in preventing or prosecuting the perpetration of a fraud upon us, or if we reasonably believe that illegal activities have been conducted. We will also disclose information where permitted or required by law to do so.

- Various industry and professional organizations conduct scientific and actuarial research studies to learn more about the risk experience of insureds. Other organizations conduct studies relating to medical research. These studies are purely scientific in nature, never identify individuals in their reports, and always maintain information provided in a highly confidential manner. When asked to provide information to such organizations, we ordinarily will do so because the results of such studies are of benefit to our customers and to the public at large. You will not be individually identified in any report that results from the research, and material that we give to the person or organization performing the research will be returned to us or destroyed when it is no longer needed.

- If you are covered under an HCSC group policy, we may disclose information as is reasonably necessary to the group for purposes of administration of the group policy and to permit the group to audit, review and evaluate the performance of HCSC under the group policy.

- We are sometimes approached by persons or organizations who are interested in the opportunity to market products or services to our customers. When this happens, we may provide some limited information. However, if we want to give information to persons not affiliated with us, we will give you an opportunity to indicate to us that you do not want information to be disclosed for this purpose. We will give information to HCSC affiliates so that our customers may be made aware of the insurance products and services offered by affiliates of HCSC.

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

Your Right to Access to Personal Information

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

1. If you have any questions about what information we may have on file about you, please write us at the address indicated at the end of this notice. We will need your complete name, address, date of birth and all policy numbers under which you are insured. Tell us what information you would like to receive. Within 30 days of our receipt of your written request, we will:

   a. inform you of the nature and substance of the recorded personal information in writing, by telephone or by other oral communication;

   b. permit you to see and copy, in person (by appointment only) the recorded personal information which applies to you or provide you with copies of this information by mail, whichever you prefer. If such information is in coded form, an accurate translation in plain language will be provided to you in writing;

   c. inform you of the persons, if recorded, to which the personal information has been disclosed within two years of your request. If the identities have not been recorded, we will provide you with the names of those insurance institutions, agents, insurance-support organizations or other persons to whom such information is normally disclosed;

   d. provide you with a summary of the procedures by which you may request correction or deletion of recorded personal information.

2. Medical-record information provided by a medical-professional will be supplied, along with the source of information, to you; or you will be notified that it has been disclosed to a medical professional you have designated and who is licensed to provide medical care with respect to the condition to which the information applies.

3. We may charge you a reasonable fee to cover the costs incurred in providing you with a copy of recorded personal information. If the information applies to reasons for an adverse underwriting decision, there will be no charge.

4. In some circumstances, our obligations to you regarding access to recorded personal information exists to the extent that the information is collected and maintained in connection with an insurance transaction. These rights do not extend to information about you that relates to and is collected in connection with or in reasonable anticipation of a claim or civil or criminal proceeding.

Your Right to Correct Personal Information

As an individual, you have the following rights in regard to the correction, amendment or deletion of recorded personal information.

1. Within 30 days of receiving your written request to correct, amend or delete any recorded personal information we have, we will

   a. correct, amend or delete the portion of the recorded personal information in dispute; or

   b. notify you of our refusal to make the correction, amendment or deletion, the reasons for the refusal and your right to file a protest statement.

2. If the recorded personal information is corrected, amended or deleted, you will be notified in writing and this information will be furnished to:

   a. any person you have designed who may have, within the preceding 2 years, received such recorded personal information;

   b. any insurance-support organization whose primary source of personal information is insurance institutions, if it has systematically received such recorded personal information from us within the preceding 7 years, unless the insurance-support organization no longer maintains recorded personal information about you;

   c. any insurance-support organization that furnished the personal information that has been corrected, amended or deleted.

3. If you disagree with a refusal to correct, amend or delete recorded personal information, you may file a:

   a. concise statement setting forth what you think is the correct, relevant or fair information, and

   b. concise statement of the reasons why you disagree with the refusal to correct, amend or delete recorded personal information.

4. If you file either of the statements described above, we will:

   a. file the statement with the disputed personal information and provide a means by which anyone reviewing the disputed personal information will be made aware of the statement and have access to it;

   b. in any subsequent disclosure of the recorded personal information that is the subject of disagreement, clearly identify the information in dispute and provide the statements along with the recorded personal information being disclosed;

   c. furnish the statement to any of the three categories of persons and organizations covered in the preceding point "2."

5. Your rights to correct, amend or delete recorded personal information exist to the extent that the information is collected and maintained in connection with an insurance transaction. These rights do not extend to information about you that relates to and is collected in connection with or in reasonable anticipation of a claim or civil or criminal proceeding.

Your Privacy is Our Concern

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

HEALTH CARE SERVICE CORPORATION,
A MUTUAL LEGAL RESERVE COMPANY
P.O. Box 1637
Chicago, Illinois 60690-1637