# CHILDREN'S BASIC HOSPITAL AND MEDICAL/SURGICAL EXPENSE POLICY

BlueCross BlueShield
of Illinois

Health Care Service Corporation, a Mutual Legal Reserve Company

IBCBI HCSC Rev. 4/04

## 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 or for non-payment of premium. Blue Cross and Blue Shield can refuse to renew this Policy only for the following reasons:

1. If every Policy bearing this Policy form number, DB-27 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 at 12:30 p.m. on the last Tuesday in October.

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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 ..... $2,000,000

## DEDUCTIBLES

Calendar Year Deductible ..... **$500**

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

## OUT-OF-POCKET EXPENSE LIMITS

PPO Hospital and Physician ..... **$1,000 per calendar year**

Non-PPO Hospital ..... **$4,000 per calendar year**

## 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 in benefits**

Additional Opinion Payment Level ..... **100% of the Usual and Customary Fee, no Deductible**
(only if required by the MSA)

## BENEFIT PAYMENT LEVELS

### Hospital Benefits

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

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

### Emergency Care

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

Emergency Medical Care – Hospital and Physician ..... **80% of the Eligible Charge or Usual and Customary Fee, no Deductible**
(Inpatient admission required within 72 hours of Emergency Medical Care)

# ELIGIBILITY AND PREMIUM INFORMATION

## APPLICATION FOR COVERAGE

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

## BLUE CROSS AND BLUE SHIELD ID CARD

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

## ELIGIBILITY, LIMITING AGE AND TERMINATION OF COVERAGE

This Policy is only available on an Individual Coverage basis. The benefits of this Policy will only be provided for you, the person for whom application for coverage was made and whose application was accepted by Blue Cross and Blue Shield. Coverage will not be provided for any other members of your family.

Coverage is available under this Policy from your Coverage Date until your 20th birthday or, if you are a full-time student, until your 25th birthday, as long as you are unmarried and an Illinois resident. Should you marry while covered under this Policy, your coverage will end as of the date of marriage. In addition, coverage is not provided under this Policy for persons who are eligible for Medicare. Should you become eligible for Medicare while covered under this Policy, your coverage will automatically terminate on the day you become eligible.

## CONVERSION PRIVILEGE

Should you become ineligible for coverage under this Policy due to reaching the limiting age, marrying or becoming eligible for Medicare, you may convert to a separate "Conversion Policy" of the type generally offered to persons in your age or eligibility classification. Evidence of Insurability will not be required and any Pre-Existing Conditions waiting period applicable to the Conversion Policy will be considered as being met to the extent that such waiting period was satisfied under this Policy.

## PAYMENT OF PREMIUM

Your first premium payment is due on your Coverage Date. Later premiums are due and payable on the due date, which will appear on your billing statement. Your first premium is based upon your age at the time your coverage begins.

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

- any premium due date, provided Blue Cross and Blue Shield notifies you of the new premium amount at least 30 days in advance of such premium due date;
- whenever the benefits of this Policy are increased, which may occur whenever required by law or whenever Blue Cross and Blue Shield gives notice of an increase in benefits;

- whenever you attain an age which results in a change in the premium amount due for that age category of coverage.

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

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

## REINSTATEMENT

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

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

## EXTENSION OF BENEFITS IN CASE OF TERMINATION

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

# WAITING PERIOD AND PROGRAM PAYMENT PROVISIONS

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

## PRE-EXISTING CONDITIONS WAITING PERIOD

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

Any Pre-Existing Condition which has not been identified on your application for coverage will be subject to a Pre-Existing Conditions waiting period of **365 days.** This Pre-Existing Conditions waiting period will begin on your Coverage Date and will continue for 365 days. Until the Pre-Existing Conditions waiting period has ended, benefits will not be provided for the Pre-Existing Condition(s).

## DEDUCTIBLES

Each calendar year you must satisfy a **$500 Deductible** before receiving benefits under this Policy. After you have Claims for more than $500 in Covered Services in a calendar year, your benefits will begin. In addition to this calendar year Deductible, you must satisfy a separate **$300 Inpatient Hospital Deductible** each time you are admitted to a Non-PPO Hospital or Non-Plan Hospital.

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

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

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

## OUT-OF-POCKET EXPENSE LIMIT

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

### — For PPO Hospitals and Physician Covered Services

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

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

- the calendar year Deductible;

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

**— For Non-PPO Hospitals**

If, during one calendar year, your out-of-pocket expenses for Covered Services rendered by a Non-PPO Hospital equal $4,000, any additional eligible Claims for Covered Services rendered by a Non-PPO Hospital (except as excluded below) that you may have during that calendar year will be paid at 100% of the Eligible Charge.

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

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

## LIFETIME MAXIMUM

The total maximum amount of benefits to which you are entitled under this Policy is **$2,000,000.**

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

# MEDICAL SERVICES ADVISORY PROGRAM (MSA)

Blue Cross and Blue Shield has established the Medical Services Advisory Office (MSA) to perform pre-admission review and length of stay review for your Inpatient Hospital services. The MSA is staffed primarily by registered nurses and other personnel with medical backgrounds. The Physicians in our Medical Department are also an essential part of the MSA.

Failure to contact the MSA or to comply with the recommendations of the MSA will result in your receiving lesser benefits.

## INPATIENT HOSPITAL SERVICES

### Pre-Admission Review

**Pre-Admission Review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations and exclusions of this Policy.**

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

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

### Emergency Admission Review

**Emergency Admission Review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations and exclusions of this Policy.**

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

### Length of Stay Review

**Length of Stay Review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations and exclusions of this Policy.**

Upon completion of the pre-admission or emergency admission review, the MSA will send you a letter confirming that you or your representative called the MSA regarding hospitalization. A letter assigning a length of stay to the admission will be sent to the admitting Physician and the Hospital.

Upon expiration of your assigned length of stay, the MSA will check with the Hospital to see if discharge has taken place. If discharge has not taken place, the MSA will obtain information on your clinical condition from the attending Physician or from the Hospital. An extension of the length of stay will be based solely on whether continued Inpatient care is Medically Necessary in the reasonable judgment of the MSA. Your Physician and the Hospital will be notified, in writing, by the MSA of the assigned length of stay extension. In the event that

the extension is determined not to be warranted according to the criteria for Medically Necessary care, the length of stay will not be extended, and the case will be referred to a Blue Cross and Blue Shield Physician for review.

## MEDICALLY NECESSARY DETERMINATION

The decision that Inpatient care, in the pre-admission phase, and continued Inpatient care, in the length of stay extension phase, does not meet the criteria for Medically Necessary care will be determined by a Blue Cross and Blue Shield Physician. Should the Blue Cross and Blue Shield Physician find 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 OPINIONS

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 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 will also be provided 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 will not in any event be liable for any act or omission of any Physician or any agent or employee of the Physician, including, but not limited to, a failure or refusal to render services to you or for providing or not providing you with the name of a particular Physician for your consultation.

## 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's charges once the admission has occurred. This amount is in addition to any Deductibles and/or copayments which may apply to Inpatient Hospital admissions. The penalty amount will not be eligible for subsequent consideration under the out-of-pocket expense limit provision of this Policy.

## 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 will 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 benefits provision. However, the final determination of your eligibility for these alternative benefits will be made by Blue Cross and Blue Shield, but only after approval of the alternative care 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 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 BENEFITS

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

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

The benefits of this section are subject to all of the terms and conditions of this Policy. Your benefits are also subject to the **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.

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

## INPATIENT COVERED SERVICES

### — Inpatient Hospital Care

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

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

   Benefits will be 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.

### — Inpatient Skilled Nursing Facility Care

If you have been hospitalized, you may continue your recovery as an Inpatient in a Skilled Nursing Facility. You must be admitted to the Skilled Nursing Facility within 30 days of discharge from the Hospital or a Coordinated Home Care Program. Benefits will be provided for the same services that are available to you as an Inpatient in the Hospital. Benefits will not be provided for services received in an Uncertified Skilled Nursing Facility.

### — Coordinated Home Care

Benefits will be provided for services received in a Plan Coordinated Home Care Program 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 from an Inpatient stay in a Hospital or Skilled Nursing Facility. Benefits will not be provided for services received in a Non-Plan Coordinated Home Care Program.

## BENEFIT PAYMENT FOR INPATIENT COVERED SERVICES

**PPO Provider** — **After you have met your calendar year Deductible**, benefits will be provided at **80%** of the Hospital's Eligible Charge when you receive Inpatient Covered Services in a **PPO Hospital**, in a **Plan Coordinated Home Care Program of a PPO Hospital** or in a **Plan Skilled Nursing Facility**.

**Non-PPO Provider** — When you receive Inpatient Covered Services in a **Non-PPO Hospital** or in a **Plan Coordinated Home Care Program of a Non-PPO Hospital**, benefits will be provided at **60%** of the Eligible Charge, after you have met your calendar year Deductible and, for Non-PPO Hospital services, a separate **$300 Inpatient Non-PPO Hospital Deductible.**

**Non-Plan Provider** — When you receive Inpatient Covered Services in a **Non-Plan Hospital** or in a **Non-Plan Skilled Nursing Facility**, benefits will be provided at **50%** of the Eligible Charge after you have met your calendar year Deductible and, for Non-Plan Hospital services, a separate **$300 Inpatient Non-Plan Hospital Deductible.**

### Emergency Admissions

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

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

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

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

**1-800-852-5890**

## OUTPATIENT COVERED SERVICES

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

1. **Surgery** and any related Diagnostic Service received on the same day as the Surgery. In addition to Surgery in a Hospital, benefits will be provided for Outpatient Surgery performed in an Ambulatory Surgical Facility. Benefits will also be provided for pre-operative tests given to you as an Outpatient to prepare you for Surgery except that benefits will not be provided for such tests if you cancel or postpone the Surgery.
2. **Radiation therapy treatments**
3. **Chemotherapy**
4. **Renal Dialysis Treatments** – these treatments are eligible for benefits if you receive them in a Hospital, in a Dialysis Facility or in your home under the supervision of a Hospital or Dialysis Facility.

5. **Emergency Accident Care** – treatment must occur within 72 hours of the accident.
6. **Emergency Medical Care** – benefits will be provided only if you are admitted to the Hospital as an Inpatient for the same illness within 72 hours of the Emergency Medical Care.
7. **Mammograms**

## BENEFIT PAYMENT FOR OUTPATIENT COVERED SERVICES

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

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

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

## WHEN SERVICES ARE NOT AVAILABLE IN A PPO HOSPITAL

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

# PHYSICIAN BENEFITS

This section of your Policy explains what services are covered and how much will be paid when you receive care from a Physician. The benefits of this section are subject to all of the terms and conditions of this Policy including the **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. **This Policy does not provide any benefits for Substance Abuse Rehabilitation Treatment or the treatment of Mental Illness**.

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

## COVERED SERVICES

### — Surgery

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

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

The following services are also part of your surgical benefits:

- **Anesthesia** – If administered at the same time as a covered surgical procedure by a Physician other than the operating surgeon or by a CRNA.
- **An Assistant Surgeon** – Services by a Physician, Dentist or Podiatrist who assists the operating surgeon in performing covered Surgery, but only if a Hospital intern or resident is not available for such assistance.

### — Medical Care

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

### — Consultations

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

- **Mammograms**
- **Radiation Therapy Treatments**
- **Chemotherapy**
- **Emergency Accident Care** – treatment must occur within 72 hours of the accident.
- **Emergency Medical Care** – benefits will be provided only if you are admitted to the Hospital as an Inpatient for the same illness within 72 hours of the Emergency Medical Care.

## BENEFIT PAYMENT FOR PHYSICIAN SERVICES

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

# OTHER COVERED SERVICES

## COVERED SERVICES

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

— **Ambulance Transportation** – when rendered in connection with a covered Inpatient admission or covered Emergency Accident Care or covered Emergency Medical Care. Benefits will not be provided for long distance trips.

— **Dental accident care** – dental services rendered by a Dentist or Physician which are required as the result of an accidental injury. However, these services are covered only if the injury occurred on or after your Coverage Date.

— **Prosthetic appliances** – Benefits will be provided for prosthetic devices, special appliances and surgical implants required by you for an illness or injury beginning on or after your Coverage Date when:

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

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

## BENEFIT PAYMENT FOR OTHER COVERED SERVICES

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

# SPECIAL CONDITIONS

## COMPLICATIONS OF PREGNANCY

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

## HUMAN ORGAN TRANSPLANTS

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

Benefits are available for both the recipient and donor of a covered transplant as follows:

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

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

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

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

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

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

# EXCLUSIONS–WHAT IS NOT COVERED

— **Hospitalization, services and supplies which are not Medically Necessary.**

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

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

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

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

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

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

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

If your Claim for benefits is denied on the basis that the services or supplies were not Medically Necessary, and you disagree with Blue Cross and Blue Shield's decision, your Policy provides for an appeal

of that decision. You must exercise your right to this appeal as a precondition to the taking of any further action against Blue Cross and Blue Shield, either at law or in equity. To initiate your appeal, you must give Blue Cross and Blue Shield written notice of your intention to do so within 60 days after you have been notified that your Claim has been denied by writing to:

Claim Review Section
Blue Cross and Blue Shield
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 any illness or injury arising out of or in the course of employment for which benefits are available under any Worker's Compensation Law or other similar laws whether or not you make a claim for such compensation or receive such benefits.

— Services or supplies that are furnished to you by the local, state or federal government and for any services or supplies to the extent payment or benefits are provided or available from the local, state or federal government (for example, Medicare) whether or not that payment or benefits are received, except as otherwise provided by law.

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

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

— Investigational Services and Supplies and all related services and supplies.

— Custodial Care Service.

— Outpatient Medical Care including, but not limited to, routine physical examinations.

— Immunizations.

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

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

— Outpatient drugs or medicines except for immunosuppressive drugs prescribed in connection with a human organ transplant.

— Services or supplies rendered for Substance Abuse Rehabilitation Treatment or for the treatment of Mental Illness.

— Services or supplies received during an Inpatient stay when the stay is primarily related to behavioral, social maladjustment, lack of discipline or other antisocial actions.

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

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

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

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

- Personal hygiene, comfort or convenience items commonly used for other than medical purposes, such as air conditioners, humidifiers, physical fitness equipment, televisions and telephones.
- Medical equipment or special braces, splints, specialized equipment, appliances, ambulatory apparatus, or battery or atomically controlled implants, except as specifically mentioned in this Policy.
- Procurement or use of prosthetic devices, special appliances or surgical implants which are for cosmetic purposes, the comfort and convenience of the patient, or unrelated to the treatment of a disease or injury.
- Replacement or repair of or adjustments to prosthetic devices, special appliances or surgical implants.
- Blood derivatives which are not classified as drugs in the official formularies.
- Private Duty Nursing Service.
- Eyeglasses, contact lenses or cataract lenses and the examination for prescribing or fitting of glasses or contact lenses or for determining the refractive state of the eye.
- Hearing aids or examinations for the prescription or fitting of hearing aids.
- Services and supplies rendered in connection with Temporomandibular Joint Dysfunction and Related Disorders except as otherwise specifically mentioned in this Policy.
- Treatment of flat foot conditions and the prescription of supportive devices for such conditions, treatment of subluxations of the foot, routine foot care or corrective shoes.
- Outpatient Occupational, Physical or Speech Therapy.
- Services and supplies rendered or provided for human organ or tissue transplants other than those specifically named in this Policy.
- Normal Obstetrical Service including related services and supplies.
- Services and supplies rendered or provided for the diagnosis and/or treatment of infertility including, but not limited to, Hospital services, Medical Care, therapeutic injections, fertility and other drugs, Surgery, artificial insemination and all forms of in-vitro fertilization.
- Elective sterilization.

# HOW TO FILE A CLAIM

## CLAIM FILING

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

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

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

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

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

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

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

## CLAIM PAYMENT

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

## CLAIM REVIEW PROCEDURES

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

If your Claim is denied (in whole or in part), you will receive a written explanation of the denial. Should your Claim be denied (or if 180 days have elapsed since it was filed and you have not received a written decision),

you may have your Claim reviewed. To do so, you must request a review no later than 60 days after the denial (or after the end of the 180 day period) by writing to:

**Claim Review Section**
**Blue Cross and Blue Shield**
**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 process as long as you inform Blue Cross and Blue Shield, in writing, of the name of the person who will represent you.

## DEPARTMENT OF INSURANCE ADDRESS

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

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

**or**

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

# GENERAL PROVISIONS

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

Blue Cross and Blue Shield hereby informs you that it has contracts with certain Providers (Plan Providers) in Illinois to provide and pay for health care services to all persons entitled to health care benefits under individual and group policies and contracts to which Blue Cross and Blue Shield is a party, including all persons covered under this Policy. 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. Under this Policy, Blue Cross and Blue Shield has the right to make any benefit payment either to you or directly to the Provider of the Covered Services. For example, Blue Cross and Blue Shield may pay benefits to you if you receive Covered Services at a Non–Plan Hospital. Blue Cross and Blue Shield is specifically authorized by you to determine to whom any benefit payment should be made.

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

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

## 3. PROVIDER RELATIONSHIPS

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

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

c. The use of an adjective such as Plan or Participating in modifying a Provider shall in no way be construed as a recommendation, referral or any other statement as to the ability or quality of such Provider. In addition, the omission, non-use or non-designation of Plan, Participating or any similar modifier or the use of a term such as Non-Plan or Non-PPO should not be construed as carrying any statement or inference, negative or positive, as to the skill or quality of such Provider.

## 4. ENTIRE POLICY; CHANGES

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

## 5. NOTICES

Any information or notice which you furnish to Blue Cross and Blue Shield under this Policy must be in writing and sent to Blue Cross and Blue Shield 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

Blue Cross and Blue Shield will refund any unearned premium 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 deceased 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 law of the State of Illinois.

# REIMBURSEMENT PROVISION

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

- 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; and
- 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 or assistance or provide any documents that Blue Cross and Blue Shield may request in order to obtain its rights under this provision.

# DEFINITIONS

Throughout this Policy, many words are used which have a specific meaning when applied to your health care coverage. These terms will always begin with a **capital letter**. When you come across these terms while reading this Policy, please refer to these definitions because they contain important limitations and special conditions that are applicable to your benefits.

**Ambulance Transportation** ..... means local transportation in a specially equipped duly certified vehicle from your home or scene of accident or medical emergency to a Hospital, between Hospital and Hospital, between Hospital and Skilled Nursing Facility or from a Skilled Nursing Facility or Hospital to your home when such Hospital or Skilled Nursing Facility would ordinarily be expected to have the appropriate facilities for the treatment needed and would be the nearest facility from the place where such transportation began or from the destination of such transportation. If there are no facilities in the local area equipped to provide the care needed, Ambulance Transportation then means transportation to the closest facility that can provide the necessary service.

**Ambulatory Surgical Facility** ..... means a facility other than a Hospital whose primary function is the provision of surgical procedures on an ambulatory basis and is duly licensed by the appropriate state and local authority to provide such services.

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

**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.

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

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

**Claim** ..... means notification in a form acceptable to Blue Cross and Blue Shield that service has been rendered or furnished to you. This notification must set forth in full the details of such service including, but not limited to, your name, age, sex and identification number, the name and address of the Provider, a specific itemized statement of the service rendered or furnished, the date of service, the diagnosis, the Claim Charge and any other information which Blue Cross and Blue Shield may request in connection with services rendered to you.

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

**Claim Payment** ..... means the benefit payment calculated by Blue Cross and Blue Shield, upon submission of a Claim, in accordance with the benefits specified in this Policy. All Claim Payments will be calcu-

lated on the basis of the Eligible Charge for Covered Services rendered to you, irrespective of any separate financial arrangement between Blue Cross and Blue Shield and the particular Provider. (See provisions of this Policy regarding BLUE CROSS AND BLUE SHIELD'S SEPARATE FINANCIAL ARRANGEMENTS WITH PROVIDERS.)

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

**Coordinated Home Care Program** ..... means an organized skilled patient care program initiated by a Hospital to facilitate the early discharge of its patients into 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 require Skilled Nursing Services on an intermittent basis under the direction of your Physician. Such program includes, but is not limited to, Skilled Nursing Services by, or under the supervision of, a registered professional nurse, and the services of physical therapists and hospital laboratories, and necessary medical supplies. The program does not include and is not intended to provide benefits for Private Duty Nursing Service.

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

**Non-Plan Coordinated Home Care Program** ..... means a Coordinated Home Care Program which does not meet the definition of a Plan Coordinated Home Care Program, but which has been certified as a home health agency in accordance with the guidelines established by Medicare.

**Coverage Date** ..... means the date on which your coverage under this Policy commences.

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

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

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

**Dentist** ..... means a duly licensed dentist.

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

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

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

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

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

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

**Emergency Medical Care** ..... means the initial Outpatient treatment, including necessary related Diagnostic Service, of the sudden and unexpected onset of a medical condition manifesting itself by symptoms severe enough that the absence of immediate medical attention could reasonably result in serious and permanent dysfunction of any bodily organ or part, or other serious and permanent medical consequences.

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

**Hospital** ..... means a facility which is a duly licensed institution for the care of the sick which provides service under the care of a Physician including the regular provision of bedside nursing by registered nurses. It does not include health resorts, rest homes, nursing homes, Skilled Nursing Facilities, convalescent homes, custodial homes for the aged or similar institutions.

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

**PPO Hospital** (Participating Provider Hospital) ..... means a Plan Hospital which has been designated by Blue Cross and Blue Shield of Illinois as a participating Hospital in Blue Cross and Blue Shield's Participating Provider Option program.

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

**Individual Coverage** ..... means coverage under this Policy for yourself only, not for any other family members.

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

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

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

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

**Medically Necessary** - SEE THE EXCLUSIONS SECTION OF THIS POLICY.

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

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

**Normal Obstetrical Service** ..... means the services rendered for normal pregnancy. A normal pregnancy means an intrauterine pregnancy which, through vaginal delivery, results in an infant, alive or dead, who weighs 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 medical conditions, suspected genetic abnormality, all of which make complications more likely, will be considered as part of a normal pregnancy.

**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.

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

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

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

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

**Podiatrist** ..... means a duly licensed podiatrist.

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

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

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

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

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

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

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

**Skilled Nursing Facility** ..... means an institution or a distinct part of an institution which 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 governmental authority to provide such services. It does not include institutions which provide only minimal care, custodial care, ambulatory or part-time care services or institutions which primarily provide for the care and treatment of Mental Illness, pulmonary tuberculosis or Substance Abuse.

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

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

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

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

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

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

**Substance Abuse Rehabilitation Treatment** ..... means an organized, intensive, structured, rehabilitative treatment program of either a Hospital or Substance Abuse treatment facility.

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

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

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

# INDEX

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## T

BlueCross BlueShield
of Illinois

# RIDER TO THE CERTIFICATE OR POLICY REGARDING HOSPICE CARE PROGRAM

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

The benefit changes below are effective January 1, 2004.

## A. DEFINITIONS SECTION

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

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

## B. HOSPICE CARE PROGRAM

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

### HOSPICE CARE PROGRAM

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

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

The following services are covered under the Hospice Care Program:

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

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

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

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

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

## C. EXCLUSIONS

The following exclusion is added:

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

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

Attest:

Hugo Tagli Jr.

Secretary

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

Raymond F. McCauley

President

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

Effective Date of Rider: July 1, 1996

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

### A. DEFINITIONS

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

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

### B. GENERAL PROVISIONS

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

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

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

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

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

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

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

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

were 30%, the $1,000 Hospital bill would be reduced by 30% to $700 for purposes of calculating your Deductible and Coinsurance amounts, and whether you have reached any out-of-pocket or benefit maximums.

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

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

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

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

Attest:

Hugo Tagli Jr.

Secretary

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

Raymond D McClarey

President

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

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

## A. DEFINITIONS

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

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

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

## B. SPECIAL CONDITIONS

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

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

## C. EXCLUSIONS- WHAT IS NOT COVERED

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

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

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

Attest:

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

Brian Van Vlissingen
Secretary

Raymond P. McCauley
President

# RIDER TO THE POLICY REGARDING BENEFIT CHANGES

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

## A. BENEFITS HIGHLIGHTS

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

**Emergency Care**

**Copayment** ..... **$125**

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

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

## B. WAITING PERIOD AND PROGRAM PAYMENT PROVISIONS

### OUT OF POCKET EXPENSE LIMIT

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

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

## C. HOSPITAL BENEFITS

### OUTPATIENT COVERED SERVICES

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

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

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

**Emergency Medical Care**

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

### BENEFIT PAYMENT FOR OUTPATIENT COVERED SERVICES

The following paragraph is hereby added:

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

## D. PHYSICIAN BENEFITS

### COVERED SERVICES

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

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

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

**Emergency Medical Care** :

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

### BENEFIT PAYMENT FOR PHYSICIAN SERVICES

The following paragraph is hereby added:

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

## E. EXCLUSIONS - WHAT IS NOT COVERED

**The following exclusions, if applicable, are deleted:**

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

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

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

**The following exclusion is added:**

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

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

Attest:

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

Brian Van Vliet Secretary

Raymond D. McCarley President

# RIDER TO THE POLICY REGARDING
# EXCLUSIONS AND GENERAL PROVISIONS

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

1. **EXCLUSIONS- WHAT IS NOT COVERED**

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

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

2. **GENERAL PROVISIONS**

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

      **TIME LIMIT ON CERTAIN DEFENSES**

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

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

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

      **Severability**

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

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

Attest:

Brian Van Vlierbergen
Secretary

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

Raymond J. McCarley
President

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

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

## A. DEFINITIONS SECTION

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

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

   (i) a group health plan;

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

   (iii) Medicare (Parts A, B or C of Title XVIII of the Social Security Act);

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

   (v) military service-related care;

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

   (vii) a State health benefits risk pool;

   (viii) the Federal Employees Health Benefits Program;

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

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

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

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

3. The following term and definition is added:

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

## B. HOSPITAL BENEFITS or HOSPITAL BENEFIT SECTION

The following is added to the Outpatient Covered Services provision:

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

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

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

## C. MAJOR MEDICAL BENEFIT SECTION or PHYSICIAN BENEFIT SECTION

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

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

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

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

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

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

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

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

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

Attest:

Hugo Tagli Jr.
Secretary

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

Raymond R. McCauley
President

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

(Applicable to Policy DB-21 HCSC)

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

The following provision is hereby added to your Policy:

### GUARANTEED RENEWABILITY

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

1. If every Policy that bears this Policy form number, DB-21 HCSC, is not renewed. If this should occur:
   a. Blue Cross and Blue Shield will give you at least 90 days prior written notice.
   b. You may convert to any other individual policy Blue Cross and Blue Shield offers to the individual market.
2. In the event of fraud or an intentional misrepresentation of material fact under the terms of this Policy. In this case, Blue Cross and Blue Shield will give you at least 30 days prior written notice.

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

### DEFINITIONS SECTION

The following definitions are hereby added:

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

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

(i) a group health plan;

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

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

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

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

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

(vii) a State health benefits risk pool;

(viii) the Federal Employees Health Benefits Program;

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

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

### COVERAGE AND PREMIUM INFORMATION

#### TERMINATION OF COVERAGE

The TERMINATION OF COVERAGE provision is hereby deleted.

#### CONVERSION PRIVILEGE

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

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

The following provision is hereby added to your Policy:

**CERTIFICATE OF CREDITABLE COVERAGE**

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

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

Attest:

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

Secretary

President

BlueCross BlueShield
of Illinois

# HIPAA NOTICE OF PRIVACY PRACTICES

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

## PLEASE REVIEW IT CAREFULLY.

### Our Responsibilities

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

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

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

### Uses and Disclosures of Protected Health Information

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

## Individual Rights

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

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

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

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

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

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

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

## Questions and Complaints

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

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

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

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

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

# OMNIBUS RIDER TO THE POLICY

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

## A. HOSPITAL BENEFIT SECTION

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

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

## B. PHYSICIAN BENEFIT SECTION

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

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

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

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

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

   **Chiropractic and Osteopathic Manipulation**

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

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

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

## C. OTHER COVERED SERVICES

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

## D. EXCLUSIONS – WHAT IS NOT COVERED

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

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

## E. HOW TO FILE A CLAIM

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

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

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

or

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

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

Attest:

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

Raymond F. McCaskey
President

Thomas C. Lubben
Secretary

# OMNIBUS RIDER TO THE POLICY

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

**DEFINITIONS SECTION**

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

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

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

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

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

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

Attest:

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

Deborah Dorman-Rodriguez

Deborah Dorman-Rodriguez
Secretary

Patricia A Hemingway Hall

Patricia A. Hemingway Hall
President and CEO

# RIDER TO THE POLICY

Effective Date: January 1, 2012

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

## GENERAL PROVISIONS

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

### PREMIUM REBATES, PREMIUM ABATEMENTS AND COST-SHARING

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

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

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

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

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

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

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

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

Attest:

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

Deborah Dorman-Rodriguez
Secretary

Patricia A. Hemingway Hall
President

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

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

## A. DEFINITIONS SECTION

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

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

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

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

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

## B. HOSPITAL BENEFIT SECTION

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

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

## C. PHYSICIAN BENEFIT SECTION

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

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

## D. SPECIAL CONDITIONS AND PAYMENTS

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

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

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

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

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

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

b. **HABILITATIVE SERVICES**

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

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

c. **ROUTINE MAMMOGRAMS**

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

— one baseline mammogram for women age 35-39

— an annual mammogram for women age 40 or older

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

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

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

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

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

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

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

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

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

**E. EXCLUSIONS-WHAT IS NOT COVERED**

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

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

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

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

3. The following exclusion is added:

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

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

Attest:

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

Secretary

Patricia A. Hemingway Hall

President

# RIDER TO THE POLICY

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

## DEFINITIONS SECTION

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Attest:

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

Deborah Dorman-Rodriguez
Secretary

Patricia A. Heminway Hall
President

BlueCross BlueShield of Illinois

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

# Blue Access for Members℠*

## Your gateway to health information

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

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

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

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

**Blue Access Mobile℠**

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

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

# Provider Finder

## Easily search for physicians, specialists and hospitals

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

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

**Download the free Provider Finder® App for Android or iPhone**

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



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# Well onTarget℠

## Motivation and guidance on the path to health and wellness

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

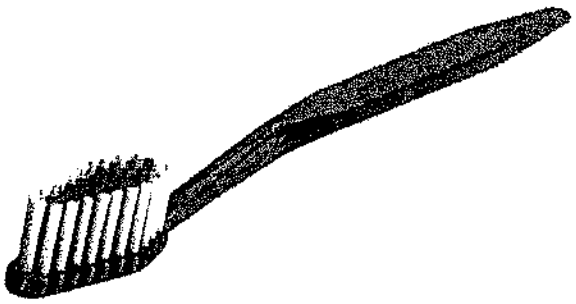
**Well onTarget includes wellness programs such as:**

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

Learn more at wellontarget.com.

# BlueCare® Dental PPO

## For individuals and families



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

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

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

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

# Blue365®

## Member discount program

Blue365 is just one more advantage of being a BCBSIL member. With this program, you can save money on health care products and services that are most often not covered by your benefit plan. There are no claims to file and no referrals or pre-authorizations.

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

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

Save on eyeglasses as well as contact lenses, laser vision correction services, examinations and accessories. Find out more when you log in to BAM. For a list of Davis Vision providers near you, go to bcbsil.com, click Find a Doctor, then select Find a Vision Provider. The Davis Vision network has major national and regional retail locations as well as independent ophthalmologists and optometrists. You and your eligible dependents can receive discounts on laser vision correction services through the TLC/TruVision network.

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

Jenny Craig can help you reach your weight loss goals. You will get one-on-one support from a trained weight loss expert. Your consultant will give you a tailored program based on the basic components of successful weight management: food, body, mind. You can meet with your consultant in person at a local center. Or you can enjoy the ease of the Jenny Craig At Home program. To get a special savings coupon, log in to BAM.

**Life Time® Fitness**

Life Time Fitness offers a total health fitness experience no matter your fitness level, interests, schedule or budget. For new members, Life Time Fitness offers a $0 enrollment fee when you sign up online.* Log in to BAM and access the Life Time Fitness website to find a free, seven-day pass to try out the location nearest you.

**Procter & Gamble (P&G) Dental Products**
**877-333-0121**

Get savings on dental packages containing the latest in Oral B® power toothbrushes and Crest® products. The dental packages from P&G can help you improve the health of your teeth and gums. Packages may contain items such as an electronic toothbrush, mouth rinse, floss, and many more. To shop in the P&G estore, log in to BAM and click on Member Discounts under Quick Links.

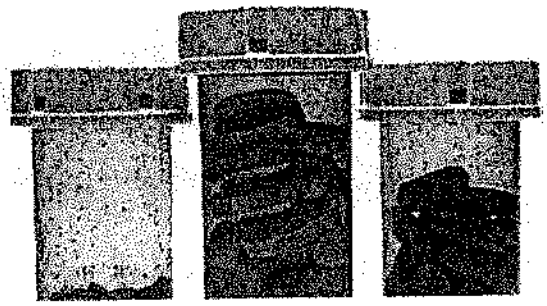
** Proof of Blue Cross and Blue Shield of Illinois coverage is needed. The $0 enrollment fee offer is only for new members who enroll online at www.Blue365Deals.com/BCBSIL/. A $35 administrative fee applies to all memberships. Monthly dues and taxes may also apply. Members' prices, dues and fees may change at any time. Offer expires September 1, 2013. Other rules may apply. Always check with the Life Time Fitness club in your area for the most up-to-date offer. Offer not available in Minnesota.*

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

*Blue365 is a discount program only for BCBSIL members. This is NOT insurance. Some of the services offered through this program may be covered under your health plan. Please check your benefit booklet or call the customer service number on the back of your ID card for specific benefit facts. Use of Blue365 does not change your monthly payment, nor do costs of the services or products count toward any maximums and/or plan deductibles. Discounts are only given through vendors who take part in this program. BCBSIL does not guarantee or make any claims or recommendations about the program's services or products. You may want to talk to your doctor before using these services and products. BCBSIL reserves the right to stop or change this program at any time without notice.*

# Mail service for prescriptions

## It's all about convenience



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

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

# Travel with confidence

## You're covered!


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

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

# Learn more about taking care of your health

**Facebook**
facebook.com/
bluecrossblueshieldofillinois

**Twitter**
twitter.com/bcbsil

**YouTube**
youtube.com/bcbsil

BlueCross BlueShield of Illinois

**To Use or Disclose Protected Health Information (PHI)**

# Standard Authorization Form

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

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

## II. Authorization and Purpose:

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

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

## III. Specific Description of Information to be Used or Disclosed

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

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

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

Yes ☐
No ☐

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

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

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

## IV. Expiration and Revocation

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

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

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

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

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

_____ _____

**Signature** **Date: month/day/year**

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

_____ _____

**Personal Representative's Name** **Relationship to Individual**

_____ _____ _____ _____

**Personal Representative's Address** **City** **State** **ZIP**

_____

**Personal Representative's Area Code & Telephone Number**

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

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

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

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

## RIDER TO THE POLICY

Effective Date: 10/01/2010

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

**EXCLUSIONS—WHAT IS NOT COVERED**

The hearing aid exclusion is revised to read as follows:

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

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

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

Jeffrey R. Tikkanen
President, Retail Markets

# RIDER TO THE POLICY TO IMPLEMENT
# ILLINOIS WELLNESS COVERAGE

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

The changes below are effective June 1, 2010.

## GENERAL PROVISIONS

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

**VALUE BASED DESIGN PROGRAMS**

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

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

**Attest:**

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

Karen Atwood

**Karen Atwood**
**President**

## RIDER TO THE POLICY REGARDING DEPENDENT LIMITING AGE

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

**COVERAGE AND PREMIUM INFORMATION**

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

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

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

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

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

Attest:

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

Deborah Dorman-Rodriguez
Secretary

Patricia A. Hemingway Hall
President and CEO

# OMNIBUS RIDER TO THE POLICY

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

## A. PHYSICIAN BENEFIT SECTION

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

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

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

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

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

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

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

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

## B. SPECIAL CONDITIONS

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

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

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

Attest:

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

Deborah Dorman-Rodriguez
Secretary

Patricia A. Hemingway Hall
President and CEO

DB-A65 HCSC

# OMNIBUS RIDER TO THE POLICY

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

A. PHYSICIAN BENEFIT SECTION

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

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

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

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

B. SPECIAL CONDITIONS

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

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

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

Attest:

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

Deborah Dorman-Rodriguez
Secretary

Patricia A. Hemingway Hall
President and CEO

DB-A66 HCSC

# OMNIBUS RIDER TO THE POLICY

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

## A. EXCLUSIONS–WHAT IS NOT COVERED

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

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

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

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

## B. HOW TO FILE A CLAIM

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

3. Mail the completed Claim Form with attachments to:

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

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

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

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

## C. GENERAL PROVISIONS

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

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

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

Attest:

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

Patricia A. Hemingway Hall

Patricia A. Hemingway Hall
President and CEO

Deborah Dorman-Rodriguez

Deborah Dorman-Rodriguez
Secretary

# BLUE CROSS AND BLUE SHIELD OF ILLINOIS (POLICY DB-27 HCSC)

*Basic Hospital and Medical/Surgical Coverage*

# OUTLINE OF COVERAGE

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

2. Basic Hospital and Medical/Surgical Expense Coverage — Policies of this category are designed to provide, to persons insured, coverage for hospital and medical/surgical expenses incurred as a result of a covered accident or sickness. Coverage is provided for daily hospital room and board, miscellaneous hospital services, hospital outpatient services, surgical services, anesthesia services, and in-hospital medical services, subject to any limitations, deductibles, and co-payment requirements set forth in the Policy. Coverage is not provided for unlimited hospital or medical/surgical expenses.

| BENEFITS | PARTICIPATING PROVIDER COVERAGE |
|---|---|
| **LIFETIME BENEFIT** | $2,000,000 |
| **DEDUCTIBLE** Per individual, per calendar year*. | $500 |
| **CARRYOVER DEDUCTIBLE** If an insured incurs a covered expense for the deductible during the last three (3) months of the calendar year, we'll carry over a credit for that part of the deductible to the following calendar year. | |
| **INPATIENT HOSPITAL SERVICES** Includes semi-private room and board; intensive care and related miscellaneous expenses for services and supplies, including pre-admission testing; prescription drugs; services of a registered physical, occupational, or speech therapist; initial expense for artificial limbs; prosthetic devices; oxygen and its administration; blood and blood plasma. | 80% |
| **INPATIENT DIAGNOSTIC SERVICES** Including, but not limited to, X-rays, lab tests, EKGs, ECGs, pathology services, pulmonary function studies, radioisotope tests, and electromyograms. | 80% |
| **OUTPATIENT DIAGNOSTIC SERVICES** Including, but not limited to, X-rays, lab tests, EKGs, ECGs, pathology services, pulmonary function studies, radioisotope tests, and electromyograms ONLY when (1) rendered on the same day as and in connection with Surgery, or (2) as part of covered emergency care. | 80% |
| **INPATIENT PHYSICIAN CHARGES** (Medical/Surgical Services) For treatment due to accident or illness while an inpatient in a hospital, Skilled Nursing Facility, or Coordinated Home Care Program; surgeon, assistant surgeon, and anesthetist fees (mental illness and substance abuse charges are NOT covered; outpatient physician charges are covered ONLY when related to emergency care.) | 80% |
| **OUTPATIENT SURGERY** Includes surgeon, assistant surgeon, and anesthetist fees; also includes surgical and anesthetic services and supplies; pre-operative tests related to the surgery. | 80% |
| **EMERGENCY CARE (Hospital and Physician)** (Deductible does not apply.) Copayment applies to Covered Services received in a Hospital emergency room or a Physician's office. Copayment does not apply to Covered Services provided for the treatment of criminal sexual assault or abuse. | $125 COPAYMENT*, THEN 80% |
| **OTHER OUTPATIENT SERVICES** Includes radiation therapy, chemotherapy, and renal dialysis treatments; and mammograms; and local ambulance service when related to covered Hospital admission or covered emergency care. | 80% |
| **HUMAN ORGAN AND TISSUE TRANSPLANTS** Includes expenses for cornea, kidney, bone marrow, heart valve, muscular/skeletal, parathyroid, heart, lung, heart/lung, liver, pancreas, or pancreas/kidney and inpatient and outpatient immunosuppressive drugs related to transplant. | 80% |
| **OUT-OF-POCKET EXPENSE LIMITS** The amount of money an individual pays toward covered expenses during any one calendar year, excluding the deductibles. Medical Services Advisory copayment, emergency care copayment, charges in excess of Usual and Customary Allowances, deductibles, and items asterisked (*) do not apply to any out-of-pocket limit. | |
| If using participating providers | $1,000 |
| If using non-participating providers | $5,000 |

# OUTLINE OF COVERAGE

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

A $300-per-admission, per-individual deductible will apply in addition to the primary deductible*. The non-participating provider out-of-pocket expense limit is $5,000, and inpatient and outpatient hospital services are covered at 60% at non-participating hospitals and 50% at non-plan hospitals.

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

## MEDICAL SERVICES ADVISORY (MSA®')

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

## GUARANTEED RENEWABILITY

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

A. If all Policies bearing form number DB-27 HCSC are not renewed, written notice will be provided at least 90 days before coverage is discontinued. Furthermore, you may convert to any other individual policy Blue Cross and Blue Shield offers to the individual market.

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

## PREMIUMS

We may change premium rates only if we do so on a class basis for all DB-27 HCSC policies. Premiums can be changed based on age, sex, and rating area.

## PRE-EXISTING CONDITIONS LIMITATION

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

## EXCLUSIONS AND LIMITATIONS

Hospitalization, services, and supplies which are not Medically Necessary. Services or supplies that are not specifically mentioned in the Policy; services or supplies for any illness or injury arising out of or in the course of employment for which benefits are available under any Workers' Compensation Law or other similar laws whether or not you make a claim for such compensation or receive such benefits; services or supplies that are furnished to you by the local, state, or federal government and for any services or supplies to the extent payment or benefits are provided or available from the local, state, or federal government (for example, Medicare) whether or not that payment or benefits are received, except as otherwise provided by law; services and supplies for any illness or injury occurring on or after your Coverage Date as a result of war or an act of war; services or supplies that do not meet accepted standards of medical and/or dental practice; investigational services and supplies and all related services and supplies; custodial care service; outpatient medical care, including but not limited to routine physical examinations; immunizations; Outpatient Diagnostic Service except when rendered on the same day as and in connection with Surgery, as part of covered Emergency Accident Care or Emergency Medical Care, or when rendered in connection with Chemotherapy or radiation therapy treatment; outpatient drugs or medicines except for immunosuppressive drugs prescribed in connection with a human organ transplant; services or supplies rendered for substance abuse rehabilitation treatment or for the treatment of mental illness; services or supplies received during an inpatient stay when the stay is primarily related to behavioral, social maladjustment, lack of discipline, or other antisocial actions; cosmetic surgery and related services and supplies, except for the correction of congenital deformities or for conditions resulting from accidental injuries, tumors, or diseases; services or supplies received from a dental or medical department or clinic maintained by an employer, labor union, or other similar person or group; services or supplies for which you are not required to make payment or would have no legal obligation to pay if you did not have this or similar coverage; charges for failure to keep a scheduled visit or charges for completion of a claim form; personal hygiene, comfort, or convenience items commonly used for other than medical purposes, such as air conditioners, humidifiers, physical fitness equipment, televisions, and telephones; blood derivatives which are not classified as drugs in the official formularies; private-duty nursing service; eyeglasses, contact lenses, or cataract lenses and the examination for prescribing or fitting of glasses or contact lenses or for determining the refractive state of the eye; hearing aids or examinations for the prescription or fitting of hearing aids; services and supplies rendered in connection with Temporomandibular Joint Dysfunction and related disorders except as otherwise specifically mentioned in the Policy; treatment of flat foot conditions and the prescription of supportive devices for such conditions, treatment of subluxations of the foot, routine foot care, or corrective shoes; procurement or use of prosthetic devices, special appliances, 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; replacement or repair of or adjustments to prosthetic devices, special appliances, or surgical implants; outpatient occupational, physical, or speech therapy; normal obstetrical service including related services and supplies; services and supplies rendered or provided for the diagnosis and/or treatment of infertility including, but not limited to, hospital services, medical care, therapeutic injections, fertility and other drugs, surgery, artificial insemination, and all forms of in-vitro fertilization; elective sterilization. Medical equipment or special braces, splints, specialized equipment, appliances, ambulatory apparatus, or battery or atomically controlled implants, except as specifically mentioned in the Policy; services and supplies rendered or provided for human organ or tissue transplants other than those specifically named in the Policy.

BlueCross BlueShield of Illinois

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

**DIRECT MARKETS**

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

®'Registered Service Mark of Health Care Service Corporation

BILOC295

## OMNIBUS RIDER TO THE CERTIFICATE OR POLICY

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

### A. DEFINITIONS SECTION

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

7. If your Certificate or Policy has a Hospice Care Program benefit, the following definition of **Hospice Care Program Service** is added replacing any previous definition of the same name:
   **HOSPICE CARE PROGRAM SERVICE**.....means a centrally administered program designed to provide for the physical, psychological and spiritual care for dying persons and their families. The goal of hospice care is to allow the dying process to proceed with a minimum of patient discomfort while maintaining dignity and a quality of life. Hospice Care Program Service is available in the home, Skilled Nursing Facility or special hospice care unit.

8. The definition of **Long Term Care Services** is added as follows:
   **LONG TERM CARE SERVICES**.....means those social services, personal care services and/or Custodial Care Services needed by you when you have lost some capacity for self-care because of a chronic illness, injury or condition.

9. The definition of **Maintenance Care** is added as follows:
   **MAINTENANCE CARE**.....means those services administered to you to maintain a level of function at which no demonstrable and/or measurable improvement of condition will occur.

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

11. The definition of **Skilled Nursing Facility** is deleted and replaced with the following:
    **SKILLED NURSING FACILITY**.....means an institution or a distinct part of an institution which is primarily engaged in providing comprehensive skilled services and rehabilitative Inpatient care and is duly licensed by the appropriate governmental authority to provide such services.

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

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

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

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

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

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

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

## B. MEDICAL SERVICES ADVISORY PROGRAM

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

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

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

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

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

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

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

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

## D. ANESTHESIA SERVICES

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

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

## E. PRIVATE DUTY NURSING SERVICE

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

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

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

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

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

## G. EXCLUSIONS–WHAT IS NOT COVERED

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

1. The exclusion regarding services and supplies which do not meet accepted standards of medical and/or dental practice is deleted in its entirety and replaced with the following:

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

2. The following exclusion is added replacing any previous exclusion regarding Investigational Services and Supplies:

   — Investigational Services and Supplies and all related services and supplies, other than the cost of routine patient care associated with Investigational cancer treatment, if those services or supplies would otherwise be covered under the Certificate or Policy if not provided in connection with an approved clinical trial program.

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

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

Attest:

Hugo Tagli Jr.
Secretary

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

President

# RIDER TO THE POLICY REGARDING REIMBURSEMENT PROVISION

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

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

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

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

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

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

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

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

DB-A36 HCSC

Attest:

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

Hugo Tagli Jr.
Secretary

Raymond R. McCauley
President

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

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

## 1. EXCLUSIONS- WHAT IS NOT COVERED

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

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

## 2. HOW TO FILE A CLAIM

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

### TIME OF PAYMENT OF CLAIMS

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

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

Attest:

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

Hugo Tagli Jr.

Secretary

Raymond D. McCarley

President

DB-A38 HCSC

# Rider to the Policy or Certificate Regarding Coordinated Home Care Program and Skilled Nursing Facility Care

Effective Date of Rider: October 1, 1995

As of the effective date indicated above, the inpatient hospital stay requirement prior to an admission in a Skilled Nursing Facility or Coordinated Home Care Program is removed. Therefore, the Policy or Certificate, to which this Rider is attached and becomes a part, is hereby amended as follows:

**1. DEFINITIONS**

The definitions of Coordinated Home Care Program and Skilled Nursing Facility in the DEFINITIONS SECTION of your Policy or Certificate are hereby deleted and replaced with the following:

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

A "Plan Coordinated Home Care Program" means a Coordinated Home Care Program which has a written agreement with Blue Cross and Blue Shield 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.

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

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 meet the definition of a Plan Skilled Nursing Facility and has not been certified in accordance with the guidelines established by Medicare.

**2. COORDINATED HOME CARE PROGRAM AND SKILLED NURSING FACILITY CARE**

The descriptions for Coordinated Home Care Program and Skilled Nursing Facility Care have been revised to read as follows:

COORDINATED HOME CARE PROGRAM

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

SKILLED NURSING FACILITY CARE

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

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

Except as amended by this Rider, all terms, conditions, limitations and exclusions of the Policy or Certificate 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)

Brian Van Vlierbergen
Secretary

Raymond F. McCauley
President