BlueCross BlueShield
of Illinois

DB-19 HCSC
OB-2111 Rev. 11/95

PARTICIPATING PROVIDER OPTION Plan 1000 Series 1

Your Health Care Benefits Policy

BlueCross BlueShield
of Illinois

An Independent Licensee of the
Blue Cross and Blue Shield Association

DB-19 HCSC Rev. 11/95

A message from

BLUE CROSS AND BLUE SHIELD

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

In this Policy we refer to our company as "Blue Cross and Blue Shield". The Definitions Section will explain the meaning of many of the terms used in this Policy. All defined terms will always begin with a capital letter. Whenever the term "you" or "your" is used, we also mean all eligible family members who are covered under Family Coverage.

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

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

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

Sincerely,

Raymond F. McCaskey
President

Brian Van Vlierbergen
Secretary

NOTICE

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

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

REIMBURSEMENT PROVISION

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

a. to immediately reimburse Blue Cross and Blue Shield for any payments received, whether by action at law, settlement or otherwise, to the extent that Blue Cross and Blue Shield has provided benefits to you or your covered dependents; and

b. that Blue Cross and Blue Shield will have a lien to the extent of benefits provided. Such lien may be filed with the person whose act caused the injury, the person's agent or a court having jurisdiction in the matter.

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

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SOME THINGS YOU SHOULD KNOW

NOTICE OF ANNUAL MEETING

You are hereby notified that you are a Member of Health Care Service Corporation, a Mutual Legal Reserve Company, and you are entitle to vote in person, or by proxy, at all meeting of Blue Cross and Blue Shield. The annual meeting is held at our principal office at 233 North Michigan Avenue, Chicago, Illinois each year on the last Tuesday in October at 12:30 p.m.

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

RIGHT TO EXAMINE THIS POLICY

You have the right to examine this Policy for a ten-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 without claim as long as you do so within the ten-day period. Any premium paid to Blue Cross and Blue Shield will be refunded to you.

CONDITIONAL RENEWABILITY

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

1. If all Policies bearing form number DB-19 HCSC are 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.

representations by any person other than Blue Cross and Blue Shield and that no person, entity, or organization other than Blue Cross and Blue Shield shall be held accountable or liable to you for any of our obligations to you created under this Policy. This paragraph shall not create any additional obligations whatsoever on the part of Blue Cross and Blue Shield other than those obligations created under other provisions of this agreement.

knowledge of or records relating to (a) any illness or injury for which a Claim or Claims for benefits are made under this Policy, (b) any medical history which might be pertinent to such illness, injury, Claim or Claims, or (c) any benefits or indemnity on account of such illness or injury or on account of any previous illness or injury which may be pertinent to such Claim or Claims, furnish to Blue Cross and Blue Shield, at any time upon its request, any and all information and records (including copies of records) relating to such illness, injury, Claim or Claims. In addition, Blue Cross and Blue Shield may furnish similar information and records (or copies of records) to other Providers, Blue Cross and Blue Shield Plans, insurance companies, governmental bodies or programs or other entities providing insurance-type benefits requesting the same.

7. LIMITATIONS OF ACTIONS

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

8. DEATH OF THE INSURED-REFUND OF PREMIUMS

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

9. TIME LIMIT ON CERTAIN DEFENSES

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

10. APPLICABLE LAW

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

11. SERVICE MARK REGULATION

You hereby acknowledge your understanding that this Policy constitutes a contract solely between you and Blue Cross and Blue Shield, that Blue Cross and Blue Shield is an independent corporation operating under a license with the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans (the "Association") permitting us to use the Blue Cross and Blue Shield Service Mark in the state of Illinois, and that we are not contracting as the agent of the Association. You further acknowledge and agree that you have not entered into this Policy based upon

BENEFIT HIGHLIGHTS

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

Deductibles

Individual Deductible. . . . . $1,000 per benefit period**

Family Deductible. . . . . .3 individual deductibles **

Non-Participating Hospital Deductible. . . . . .$300 per admission**

Out-of-Pocket Expense Limit (does not apply to all services)

— Participating Hospital. . . . . $2,500 per benefit period

— Non-Participating Hospital. . . . . $10,000 per benefit period

— Non-Plan Hospital. . . . . No limit

Family Out-of-Pocket Expense Limit. . . . . 3 individual out-of-pocket expense limits

Lifetime Maximums

Separate Lifetime Maximum for Additional Transplants Coverage. $1,000,000

Lifetime Maximum for all other benefits. $1,000,000

Combined Lifetime Maximum Inpatient and Outpatient Mental Illness and Substance Abuse Rehabilitation Treatment. $25,000**

Temporomandibular Joint Dysfunction and Related Disorders Lifetime Maximum. $1,000**

Dollar Maximums

Outpatient Physical Therapy. . . . . .$3,000 per benefit period**

Outpatient Occupational Therapy. . . . . .$3,000 per benefit period**

Outpatient Speech Therapy. . . . . .$3,000 per benefit period**

Chiropractic Services. . . . . $1,000 per benefit period**

Well Child Care. . . . . .$500 per benefit period**

Private Duty Nursing Service. . . . . .$1,000 per month**

Inpatient Substance Abuse Rehabilitation Treatment and Inpatient Mental Illness Treatment Maximum. . . . . $10,000 per benefit period**

Outpatient Substance Abuse. . . . . $1,000 per benefit period**
Rehabilitation Treatment
and Outpatient Mental
Illness Treatment Maximum

Special Program

THE MEDICAL SERVICES
ADVISORY PROGRAM. . . . . A special program designed to assist you in determining the course of treatment that will maximize your benefits under this Policy

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

Payment Levels

HOSPITAL BENEFITS

Payment level for Covered
Services in a
Participating Hospital:

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

— Inpatient Mental Illness. . . . . 80% of the Eligible Charge for the
or Substance Abuse 1st 10 days; 50% of the Eligible
Rehabilitation Treatment Charge thereafter

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

Payment level for Covered
Services in a
Non-Participating Hospital:

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

— Inpatient Mental Illness. . . . . 60% of the Eligible Charge for the
or Substance Abuse 1st 10 days; 50% of the Eligible
Rehabilitation Treatment Charge thereafter

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

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

PHYSICIAN BENEFITS

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

3. YOUR PROVIDER RELATIONSHIPS

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

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

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

4. ENTIRE POLICY; CHANGES

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

5. NOTICES

Any information or notice which you furnish to Blue Cross and Blue Shield under this Policy must be in writing and sent to Blue Cross and Blue Shield at its offices at 233 North Michigan Avenue, Chicago, Illinois 60601-5655 (unless another address has been stated in this Policy for a specific situation). Any information or notice which Blue Cross and Blue Shield furnishes to you must be in writing and sent to you at your address as it appears on Blue Cross and Blue Shield records.

6. INFORMATION AND RECORDS

You agree that it is your responsibility to insure that any Provider, other Blue Cross and Blue Shield Plan, insurance company, employee benefit association, government body or program, any other person or entity, having

d. 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 $200, then Blue Cross and Blue Shield has to satisfy the rest of the Hospital bill, or $800. Assuming Blue Cross and Blue Shield has a contract with the Hospital, Blue Cross and Blue Shield will usually be able to satisfy the $800 bill that remains after your Coinsurance and Deductible, by paying less than $800 to the Hospital, often substantially less than $800. Blue Cross and Blue Shield receives, and keeps for its own account, the difference between the $800 bill and whatever Blue Cross and Blue Shield actually pays, and you are not entitled to any part of these savings.

In addition, the portion of the bill which Blue Cross and Blue Shield has to satisfy, in this example $800, is the amount which is applied in the calculation of the maximum amount of benefits payable by Blue Cross and Blue Shield under this Policy, even though Blue Cross and Blue Shield may be able to satisfy the $800 bill by paying substantially less than $800.

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 or from a Non-Participating professional provider. Blue Cross and Blue Shield is specifically authorized by you to determine to whom any benefit payment should be made.

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

c. 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.

OTHER COVERED SERVICES

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

EMERGENCY CARE

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

OUTPATIENT MENTAL ILLNESS AND SUBSTANCE ABUSE REHABILITATION TREATMENT

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

* Usual and Customary Fee

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

TO IDENTIFY NON-PLAN AND PLAN HOSPITALS OR FACILITIES, YOU SHOULD CONTACT BLUE CROSS AND BLUE SHIELD BY CALLING THE FOLLOWING TOLL FREE NUMBER: 1-800-852-5890.

DEFINITIONS SECTION

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

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

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

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

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

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

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

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

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

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

GENERAL PROVISIONS

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

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

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

Blue Cross and Blue Shield may receive such payments, discounts and/or other allowances during the term of this Policy. You are not entitled to receive any portion of any such payments, discounts and/or other allowances. Further, the calculation of the maximum amount of benefits payable by Blue Cross and Blue Shield under this Policy and the calculation of all required Deductible and Coinsurance amounts payable by you under this Policy shall be based on the Eligible Charge or Provider's Claim Charge for Covered Services rendered to you, irrespective of any separate financial arrangement between any Plan Provider and Blue Cross and Blue Shield as referred to above.

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

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

b. You personally will have to pay the Deductible and Coinsurance amounts set out in your Policy. Both the Deductible and Coinsurance amounts are based on the Hospital's Eligible Charges, which is usually the full amount the Hospital normally bills for the Covered Services you receive, or in this example, $1,000.

c. Assuming you have already satisfied your Deductible, you will still have to pay the Coinsurance portion of the $1,000 Hospital bill. For example, if your Coinsurance obligation is 20%, you personally will have to pay 20% of $1,000, or $200. You should note that your 20% Coinsurance is based on the full $1,000 Hospital bill.

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

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

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

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

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

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

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

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

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

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

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

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

COORDINATED HOME CARE PROGRAM.....means an organized skilled patient care program in which care is provided in the home. 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 initiated by a Plan Hospital and which has a written agreement with Blue Cross and Blue Shield to provide service to you at the time service is rendered to you.

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

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

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

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

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

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

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

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

DIALYSIS FACILITY.....means a facility (other than a Hospital) whose primary function is the treatment and/or provision of maintenance and/or training dialysis

HOW TO FILE A CLAIM

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

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

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

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

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

In any case, Claims should be filed with Blue Cross and Blue Shield on or before December 31st of the calendar year following the year in which your Covered Service was rendered. (A Covered Service furnished in the last month of a particular calendar year shall be considered to have been furnished the succeeding calendar year.) **Claims not filed within the required time period will not be eligible for payment.**

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

CLAIM REVIEW PROCEDURES

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

— Diagnostic Service as part of routine physical examinations or check-ups, premarital examinations, determination of the refractive errors of the eyes, auditory problems, surveys, casefinding, research studies, screening, or similar procedures and studies, or tests which are Investigational.

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

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

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

— Maternity Service, including related services and supplies.

on an ambulatory basis for renal dialysis patients and which is duly licensed by the appropriate governmental authority to provide such services.

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

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

ELIGIBLE CHARGE.....means (a) in the case of a Provider which has a written agreement with Blue Cross and Blue Shield 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, either of the following charges for Covered Services as determined at the discretion of Blue Cross and Blue Shield:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

MATERNITY SERVICE.....means the services rendered for normal pregnancy. A normal pregnancy means an intrauterine pregnancy which, through vaginal delivery, results in an infant, who weighs 5 pounds or more.

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

— Custodial Care Service.

— Routine physical examinations, unless otherwise specified in this Policy.

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

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

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

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

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

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

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

— Blood derivatives which are not classified as drugs in the official formularies.

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

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

— Immunizations, unless otherwise specified in this Policy.

— Maintenance Occupational Therapy, Maintenance Physical Therapy and Maintenance Speech Therapy.

— Speech Therapy when rendered for the treatment of psychosocial speech delay, behavioral problems (including impulsive behavior and impulsivity syndrome), attention disorder, conceptual handicap or mental retardation.

— Hearing aids or examinations for the prescription or fitting of hearing aids.

— Services and supplies to the extent benefits are duplicated because the spouse, parent and/or child are employees of the Group and each is covered separately under this Policy.

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

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

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

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

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

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

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

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

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

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

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

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

NON-PARTICIPATING HOSPITAL.....SEE DEFINITION OF HOSPITAL.

NON-PLAN HOSPITAL.....SEE DEFINITION OF HOSPITAL.

NON-PLAN PROVIDER.....SEE DEFINITION OF PROVIDER.

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

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

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

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

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

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

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

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

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

PLAN HOSPITAL.....SEE DEFINITION OF HOSPITAL.

PLAN PROVIDER.....SEE DEFINITION OF PROVIDER.

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

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

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

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

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

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

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

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 Certificate. In

- the Coinsurance and/or Copayment resulting from Covered Services you may receive from a Participating Hospital or Plan Provider facility or from a Physician or other professional Provider
- the Coinsurance and/or Copayment resulting from Hospital services rendered by a Non-Plan Hospital or other Non-Plan Provider for Covered Services
- charges for Covered Services which have a separate dollar maximum specifically mentioned in this Policy
- Copayments resulting from noncompliance with the provisions of the Medical Services Advisory Program
- any unreimbursed expenses incurred for Comprehensive Major Medical Covered Services within your prior contract's benefit period.

If you have Family Coverage and 3 members of your family have reached their out-of-pocket expense limit during one benefit period, then, for the rest of the benefit period, all other family members will have benefits for Covered Services rendered by a Non-Participating Hospital (except for those Covered Services specifically excluded above) provided at 100% of the Eligible Charge or Usual and Customary Fee.

EXTENSION OF BENEFITS IN CASE OF TERMINATION

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

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

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

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

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

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

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

SKILLED NURSING FACILITY.....means an institution or a distinct part of an institution which 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.

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

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

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

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

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

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

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

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

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

USUAL AND CUSTOMARY FEE.....means the fee as reasonably determined by Blue Cross and Blue Shield, which is based on the fee which the Physician, Dentist, Podiatrist, Psychologist, Chiropractor or Optometrist who renders the

- the payments for which you are responsible after Comprehensive Major Medical benefits have been provided (except for any expenses incurred for Covered Services rendered by a Non-Participating Hospital, Non-Plan Hospital or other Non-Plan Provider facility other than Emergency Accident Care, Emergency Medical Care and Inpatient treatment during the period of time when your condition is life threatening)
- and any unreimbursed expenses incurred for Comprehensive Major Medical Covered Services within your prior contract's benefit period, if not completed.

It does not include:

- the Comprehensive Major Medical deductible
- charges that exceed the Eligible Charge or Usual and Customary Fee
- the Coinsurance and/or Copayment resulting from Covered Services rendered by a Non-Participating Hospital, Non-Plan Hospital or other Non-Plan Provider facility
- charges for Covered Services which have a separate dollar maximum specifically mentioned in this Policy
- Copayments resulting from noncompliance with the provisions of the Medical Services Advisory Program

If you have Family Coverage and 3 members of your family have reached their out-of-pocket expense limit during one benefit period, then, for the rest of the benefit period, all other family members will have benefits for Covered Services (except for those Covered Services specifically excluded above) provided at 100% of the Eligible Charge or Usual and Customary Fee.

For Non-Participating Hospitals

If, during one benefit period, your out-of-pocket expense (the amount remaining unpaid after benefits have been provided) equal $10,000, any additional eligible Claims for Covered Services rendered by a Non-Participating Hospital (except for those Covered Services specifically excluded below) during that benefit period will be paid in full up to the Eligible Charge.

This $10,000 may be reached by:

- the payments for Covered Services rendered by a Non-Participating Hospital for which you are responsible after the Comprehensive Major Medical benefits have been provided.

It does not include:

- the Comprehensive Major Medical deductible
- the Inpatient Hospital admission deductible
- charges that exceed the Eligible Charge or Usual and Customary Fee

Your benefits for Inpatient treatment of Mental Illness and Inpatient Substance Abuse Rehabilitation Treatment are limited to a maximum of $10,000 per benefit period.

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

A combined lifetime maximum of $25,000 will apply to benefits for Inpatient and Outpatient treatment of Mental Illness and/or Substance Abuse Rehabilitation Treatment.

COMPLICATIONS OF PREGNANCY

Benefits will be paid for Covered Services received in connection with Complications of Pregnancy.

TEMPOROMANDIBULAR JOINT DYSFUNCTION AND RELATED DISORDERS

Benefits for all of the Covered Services previously described in this Policy are available for the diagnosis and treatment of Temporomandibular Joint Dysfunction and Related Disorders. Your benefits for the diagnosis and/or treatment of Temporomandibular Joint Dysfunction and Related Disorders are limited to a lifetime maximum of $1,000.

PAYMENT PROVISIONS

Lifetime Maximum

The total maximum amount of benefits to which you are entitled under this Comprehensive Major Medical Program is $1,000,000. This is an individual maximum. There is no family maximum.

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

OUT-OF-POCKET EXPENSE LIMIT

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

For Participating Hospitals

If, during one benefit period, your out-of-pocket expense (the amount remaining unpaid after benefits have been provided) equal $2,500, any additional eligible Claims (except for those Covered Services specifically excluded below) during that benefit period will be paid in full up to the Eligible Charge or Usual and Customary Fee.

This $2,500 may be reached by:

particular services usually charges his patients for the same service and the fee which is within the range of usual fees other Physicians, Dentists, Podiatrists, Psychologists, Chiropractors or Optometrists of similar training and experience in a similar geographic area charge their patients for the same service, under similar or comparable circumstances. However, if Blue Cross and Blue Shield reasonably determines that the Usual and Customary Fee for a particular service is unreasonable because of extenuating or unusual circumstances, the Usual and Customary Fee for such service shall mean the reasonable fee as reasonably determined by Blue Cross and Blue Shield.

COVERAGE AND PREMIUM INFORMATION

YOUR APPLICATION FOR COVERAGE

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

YOUR BLUE CROSS AND BLUE SHIELD ID CARD

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

INDIVIDUAL COVERAGE

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

FAMILY COVERAGE

If you have Family Coverage, your health care expenses and those of your enrolled spouse and your (of your spouse's) enrolled unmarried children who are under age 19 will be covered. Enrolled unmarried children who are full-time students will be covered up to age 25. The coverage for unmarried children will end on the birthday.

Any newborn children will be covered from the moment of birth. Please notify Blue Cross and Blue Shield within 31 days of the date of birth so that your membership records can be adjusted.

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

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

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

PAYMENT OF PREMIUMS

4. Your first premium is due on your Coverage Date. Later premiums are due and payable on the due date, which is the date that will appear on your billing statement.
5. The premium due on any due date is the amount for either the Individual or Family Coverage for which benefits are assessed.
6. The initial premium for Individual Coverage is based on your age at the time your coverage commences and the initial premium for Family Cover-

MENTAL ILLNESS SERVICES

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

Benefit Payment for Mental Illness and Substance Abuse Rehabilitation Treatment

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

After your deductible, benefits for Outpatient Substance Abuse Rehabilitation Treatment (in a program approved by Blue Cross and Blue Shield) will be provided at 50% of the Eligible Charge or at 50% of the Usual and Customary Fee. Benefits will not be provided for Substance Abuse Rehabilitation Treatment in a program which has not been approved by Blue Cross and Blue Shield nor in a Non-Plan Substance Abuse Treatment Facility. However, your Substance Abuse Rehabilitation Treatment benefits for the treatment of alcoholism in a non-approved program or Non-Plan facility are determined differently. Benefits will be provided for the Outpatient treatment of alcoholism in a non-approved program or a Non-Plan facility at 50% of the Eligible Charge after you have met your deductible.

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

After your deductible, benefits for the Inpatient treatment of Mental Illness and Inpatient Substance Abuse Rehabilitation Treatment (in a Blue Cross and Blue Shield approved program of a Participating Hospital or a Plan Facility) will be provided at 80% of the Eligible Charge for the first 10 days of each admission. Any remaining eligible Hospital charges will be paid at 50% of the Eligible Charge.

After you have met your deductible, benefits for the Inpatient treatment of Mental Illness and Inpatient Substance Abuse Rehabilitation Treatment (in a Blue Cross and Blue Shield approved program of a Non-Participating Hospital) will be provided at 60% of the Eligible Charge for the first 10 days of each admission. Any remaining eligible Hospital charges will be paid at 50% of the Eligible Charge.

When you receive Covered Services for the Inpatient treatment of Mental Illness or alcoholism in a Non-Plan Provider facility benefits will be provided at 50% of the Eligible Charge after you have met your deductible.

When you receive Covered Services for the Inpatient treatment of Mental Illness or Inpatient Substance Abuse Rehabilitation Treatment from a Physician or other professional Provider, benefits will be provided at 80% of the Usual and Customary Fee after you have met your deductible.

- Travel time and related expenses required by a Provider.
- Drugs which are Investigational.

Your benefits for heart, lung, heart/lung, liver, pancreas and pancreas/kidney transplants are subject to a lifetime maximum of $1,000,000. This lifetime maximum is separate from your lifetime maximum for all other benefits.

SKILLED NURSING FACILITY CARE

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).

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

Benefits for Covered Services rendered in a Non-Plan Skilled Nursing Facility will be provided at 50% of the Eligible Charge, once you have met your deductible. Benefits will not be provided for Covered Services received in an Uncertified Skilled Nursing Facility.

AMBULATORY SURGICAL FACILITY

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

Benefits for Outpatient Surgery will be provided as stated above after you have met your deductible.

SUBSTANCE ABUSE REHABILITATION TREATMENT

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

Covered Services must be provided in a Blue Cross and Blue Shield approved Substance Abuse Rehabilitation Treatment program. Benefits will not be provided for Substance Abuse Rehabilitation Treatment in programs which have not been approved in writing by Blue Cross and Blue Shield nor will benefits be provided for services in a Non-Plan Substance Abuse Treatment Facility. However, your Substance Abuse Rehabilitation Treatment benefits for the treatment of alcoholism in a non-approved program or Non-Plan facility will be paid at the Non-Plan facility payment level described later in this benefit section.

age is based on the age of the person to whom this Policy is issued at the time coverage is applied for.

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

   (i) any premium due date, provided Blue Cross and Blue Shield notifies you of the new premium amount at least 30 days in advance of such premium due date, and

   (ii) whenever the benefits of this Policy are increased, which may occur whenever required by law or whenever Blue Cross and Blue Shield gives notice of an increase in benefits.

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

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

COVERAGE CHANGES

Changing from Individual to Family Coverage

You can change from Individual to Family Coverage, either because of marriage or the birth or adoption of a child, if you make application for this change within 31 days of the marriage, birth or adoption or court order. Your Family Coverage will then be effective from the date of the marriage, birth or adoption. You may obtain an application from any Blue Cross and Blue Shield office.

Changing from Family to Individual Coverage

Should you wish to change from Family to Individual Coverage, you may do so at any time. Please notify your local Blue Cross and Blue Shield Office if you wish to change to Individual Coverage.

Divorce

If you are divorced while you have Family Coverage under this Policy, your spouse shall be entitled to have issued to him or her, without Evidence of Insurability, and within 60 days following the entry of the divorce decree, a new Policy. Your dependent children may either continue coverage under your Policy, become covered under your spouse's new Policy or change to separate Individual Coverage Policies (but only if you and your spouse have both elected Individual Coverage). Any Preexisting Conditions Waiting Period applicable to the new Policy(s) shall be considered as being met to the extent that such waiting period was satisfied under this Policy.

In the event of your Death

In the event of your death, your spouse shall be entitled to have issued to him or her, without Evidence of Insurability and upon application within 60 days fol-

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

Covered Dependent Children

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

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 in connection therewith an application for reinstatement, shall reinstate the Policy; provided, however, that if Blue Cross and Blue Shield or such agent requires an application for reinstatement and issues a conditional receipt for the premium given, the Policy will be reinstated upon approval of such application by Blue Cross and Blue Shield or, lacking such approval, upon the 45th day following the date of such conditional receipt unless Blue Cross and Blue Shield has previously notified you in writing of its disapproval of such application. The reinstated Policy shall cover only loss resulting from such accidental injury as may be sustained after the date of reinstatement and loss due to such illness as may begin more than 10 days after such date. In all other respects you will have the same rights as you had under the Policy immediately before the due date of the defaulted premium, subject to any provisions endorsed and attached hereto in connection with reinstatement. Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than 60 days prior to the date of reinstatement.

TERMINATION OF COVERAGE

Your coverage under this Policy shall automatically terminate at the beginning of the month in which you reach age 65 or otherwise become eligible for Medicare. However, Blue Cross and Blue Shield will, at that time, issue you a new Policy containing provisions which are generally offered to persons in your age or eligibility classification. You may transfer to the new Policy as long as you pay Blue Cross and Blue Shield the established charges for the new coverage within 30 days of the termination of this Policy.

SPECIAL CONDITIONS AND PAYMENTS

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

HUMAN ORGAN TRANSPLANTS

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

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

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

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

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

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

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

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

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

- Cardiac rehabilitation services when not provided to the transplant recipient within 3 days after discharge from a Hospital for transplant Surgery.
- Transportation by air ambulance for the donor or the recipient.

gioplasty. Benefits will be limited to a maximum of 36 Outpatient treatment sessions within the six month period.

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

BENEFIT PAYMENT FOR OTHER COVERED SERVICES

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

MEDICAL SERVICES ADVISORY PROGRAM

Blue Cross and Blue Shield has established the office of the Medical Services Advisor (MSA) to perform preadmission review and length of stay review for your Inpatient Hospital services and treatment of Mental Illness or Substance Abuse Rehabilitation Treatment in a Partial Hospitalization Treatment Program.

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

Failure to contact the MSA or to comply with the recommendations of the MSA will result in a reduction of benefits. Please read the provisions below very carefully.

INPATIENT HOSPITAL SERVICES

- **Preadmission Review**

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

  At the time of your enrollment in the MSA program, you will receive a special MSA card that will give you the MSA's toll-free telephone number. Whenever a nonemergency or nonmaternity Inpatient Hospital admission is recommended by your Physician, you must, in order to receive maximum benefits under this Policy, call the MSA. This call should be made at least one business day prior to the scheduling of the Hospital admission and the performance of any preadmission tests.

  If the proposed Hospital admission does not meet criteria for Medically Necessary care, 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 advised by telephone 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 your 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 as well as the Preexisting Condition waiting period, if any.

  In the event of an emergency admission, you or someone who calls on your behalf must, in order to receive maximum benefits under this Policy, notify

the MSA no later than 2 business days after the admission has occurred in order to have the Inpatient Hospital admission reviewed. If the call is made any later than the specified time period, you will not be eligible for maximum benefits.

- **Partial Hospitalization Treatment Review**

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

  Whenever an admission to a Partial Hospitalization Treatment Program is recommended by your Physician, you must, in order to receive maximum benefits under this Policy, call the MSA. This call should be made at least one business day prior to the scheduling of the admission.

- **Length of Stay Review**

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

  Upon completion of the preadmission or emergency review, the MSA will send you a letter confirming that you or your representative called the MSA regarding your hospitalization. A letter assigning a length of stay to the admission will be sent to your Physician and/or 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 meet 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 preadmission phase, and continued Inpatient care, in the length of stay extension phase, does not meet criteria for Medically Necessary care will be determined by a Blue Cross and Blue Shield Physician. Should the Blue Cross and Blue Shield Physician concur that the Inpatient care or continued Inpatient care is not Medically Necessary, written notification of the decision will be provided to you, your Physician, and/or 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

b. they are required to replace all or part of the function of a non-functioning or malfunctioning organ or tissue.

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

- Chiropractic Service—When rendered by a Chiropractor or Physician. Benefits for Chiropractic Service will be limited to a maximum of $1,000 per benefit period.
- Optometric services—Benefits will be provided for services which may be legally rendered by an Optometrist, provided that benefits would have been provided had such services been rendered by a Physician.
- Physical Therapy—Benefits will be provided for Physical Therapy when rendered by a Physician or by a registered professional physical therapist under the supervision of a Physician. The therapy must be furnished under a written plan established by a Physician and regularly reviewed by the therapist and the Physician. The plan must be established before treatment is begun and must relate to the type, amount, frequency and duration of therapy and indicate the diagnosis and anticipated goals. Benefits for Outpatient Physical Therapy will be limited to a maximum of $3,000 per benefit period.
- Occupational Therapy—Benefits will be provided for Occupational Therapy when these services are rendered by a Physician or by a registered occupational therapist under the supervision of a Physician. This therapy must be furnished under a written plan established by a Physician and regularly reviewed by the therapist and the Physician. The plan must be established before treatment is begun and must relate to the type, amount, frequency and duration of therapy and indicate the diagnosis and anticipated goals. Benefits for Outpatient Occupational Therapy will be limited to a maximum of $3,000 per benefit period.
- Speech Therapy—Benefits will be provided for Speech Therapy when these services are rendered by a licensed speech therapist or speech therapist certified by the American Speech and Hearing Association. Inpatient Speech Therapy benefits will be provided only if Speech Therapy is not the only reason for admission. Outpatient Speech Therapy benefits will be limited to a maximum of $3,000 per benefit period.
- Cardiac Rehabilitation Services—Benefits will be provided for cardiac rehabilitation services only in Blue Cross and Blue Shield approved programs when these services are rendered to you within a six month period following an eligible Inpatient Hospital admission for either myocardial infarction, coronary artery bypass Surgery or percutaneous transluminal coronary an-

OTHER COVERED SERVICES

This section of your Policy describes "Other Covered Services" and the benefits that will be provided for them.

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

coverage under this Policy, see the section entitled, "EXCLUSIONS - WHAT IS NOT COVERED."

The MSA does not determine your course of treatment or whether you receive particular health care services. The decision regarding the course of treatment and receipt of particular health care services is a matter entirely between you and your Physician. The 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 Blue Cross and Blue Shield's 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.

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

MSA PROCEDURE

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

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

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

ADDITIONAL OPINION

In some instances, an additional medical/surgical opinion may be required after you contact the MSA. If this occurs, the MSA will furnish you with the names of Physicians with whom Blue Cross and Blue Shield has an agreement to render an additional opinion. Benefits for the additional opinion, when arranged by the

MSA, will be provided at 100% of the Usual and Customary Fee without application of any deductibles which might otherwise be applicable under this Policy.

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

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

APPEAL PROCEDURE

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

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

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

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

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

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

2. physical examinations

Benefits for well child care will be limited to a maximum of $500 per benefit period.

Shock therapy treatments

Radiation therapy treatments

Chemotherapy

Diagnostic Service—Benefits will be provided for those services related to covered Surgery or Medical Care.

Mammograms

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

Emergency Medical Care

BENEFIT PAYMENT FOR PHYSICIAN SERVICES

When you receive any of the Covered Services described in this Physician Benefits Section, 80% of the Usual and Customary Fee will be paid, after you have met your deductible.

However, benefits for Emergency Accident Care and Emergency Medical Care will be provided at 100% of the Usual and Customary Fee. Your deductible will not apply to these Covered Services.

3. Assistant Surgeon—that is, a Physician, Dentist or Podiatrist who assists the operating surgeon in performing covered Surgery but only if a Hospital intern or resident is not available for such assistance.

Additional Surgical Opinion

Your coverage includes benefits for an additional surgical opinion following a recommendation for elective Surgery. Your benefits will be limited to one consultation and related Diagnostic Service by a Physician. Benefits for an additional surgical opinion consultation and related Diagnostic Service will be provided at 100% of the Usual and Customary Fee. Your deductible will not apply to this benefit. If you request, benefits will be provided for an additional consultation when the need for Surgery, in your opinion, is not resolved by the first arranged consultation.

Medical Care

Benefits are available for Medical Care visits when:

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

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

Consultations

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

Well Child Care

Benefits will be provided for Covered Services provided by a Physician to children under age 16, even though they are not ill. Benefits will be limited to the following services:

1. immunizations;

FAILURE TO COMPLY WITH MSA RECOMMENDATIONS

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

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

INDIVIDUAL BENEFITS MANAGEMENT PROGRAM (IBMP)

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

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

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

Blue Cross and Blue Shield's election to provide alternative benefits in one instance shall not obligate it to provide the same or similar benefits for you in any other instance. In addition, Blue Cross and Blue Shield's offering or providing alternative benefits shall not be construed as a waiver of any of the terms, conditions, limitations or exclusions of this Policy.

THE PARTICIPATING PROVIDER OPTION

The Participating Provider Option is a program of health care benefits designed to provide you with economic incentives for using designated Providers of health care services.

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

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

YOUR BENEFIT PERIOD

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

YOUR DEDUCTIBLE

Each benefit period you must satisfy a $1,000 **Comprehensive Major Medical deductible**. In other words, after you have claims for more than $1,000 of Covered Services in a benefit period, your benefits will begin. However, each time you are admitted to a **Non-Participating Hospital or Non-Plan Hospital, you must satisfy a $300 deductible**. This deductible is in addition to your Comprehensive Major Medical deductible.

If you have Family Coverage and 3 members of your family have each satisfied their Comprehensive Major Medical deductible, it will not be necessary for anyone else in your family to meet a deductible in that benefit period. That is, for the remainder of that benefit period, no other family members are required to meet the Comprehensive Major Medical deductible before receiving benefits.

In any case, should two or more members of your family ever receive Covered Services as a result of injuries received in the same accident, only one such deductible will be applied against those Covered Services.

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

EMERGENCY ACCIDENT CARE

EMERGENCY MEDICAL CARE

ADDITIONAL SURGICAL OPINION CONSULTATIONS

PHYSICIAN BENEFIT SECTION

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

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

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

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

COVERED SERVICES

Surgery

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

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

The following services are also part of your surgical benefits:

1. Sterilization Procedures (even if they are elective).
2. Anesthesia 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.

Outpatient Hospital Covered Services

1. Surgery and any related Diagnostic Service received on the same day as the Surgery
2. Radiation therapy treatments
3. Chemotherapy
4. Shock therapy treatments
5. Renal Dialysis Treatments—if received in a Hospital, a Dialysis Facility or in your home under the supervision of a Hospital or Dialysis Facility
6. Diagnostic Service—when you are an Outpatient and these services are related to Surgery or Medical Care
7. Emergency Accident Care—treatment must occur within 72 hours of the accident
8. Emergency Medical Care
9. Mammograms

BENEFIT PAYMENT FOR OUTPATIENT HOSPITAL COVERED SERVICES

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

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

When you receive Outpatient Hospital Covered Services from a Non-Plan Hospital or other Non-Plan Provider facility, payment will be 50% of the Eligible Charge after you have met your deductible. Covered Services received for Emergency Accident Care and Emergency Medical Care from a Non-Plan Hospital or other Non-Plan Provider will be paid at the same payment level which would have been paid had such services been received from a Participating Hospital or other Participating Provider.

Benefits for Emergency Accident Care or Emergency Medical Care will be provided at 100% of the Hospital's Eligible Charge in either a Participating, Non-Participating or Non-Plan Hospital whether or not you have met your deductible.

WHEN SERVICES ARE NOT AVAILABLE IN A PARTICIPATING HOSPITAL

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

PREEXISTING CONDITIONS WAITING PERIOD

Your benefits are subject to a Preexisting Conditions waiting period of 365 days. The Preexisting Conditions waiting period will begin on the Coverage Date for you and your eligible dependents (if Family Coverage is effective) and will continue for the number of days specified. This Preexisting Conditions waiting period will also apply to each dependent (other than a newborn child) for whom coverage is applied for after your Coverage Date. The Preexisting Conditions waiting period for such a dependent will begin on the dependent's Coverage Date. Until the Preexisting Conditions waiting period has ended, no benefits will be provided for a Preexisting Condition.

HOSPITAL BENEFIT SECTION

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

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

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

The level of benefits paid for Hospital Covered Services is generally greater when received in a Plan Hospital or other Plan facility.

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

INPATIENT CARE

The following are Covered Services when you receive them as an Inpatient in a Hospital.

Inpatient Covered Services

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

Preadmission Testing

Benefits are provided for preoperative tests given to you as an Outpatient to prepare you for Surgery which you are scheduled to have as an Inpatient, provided that benefits would have been available to you had you received these tests as an Inpatient in a Hospital. Benefits will not be provided if you cancel or postpone the Surgery.

These tests are considered part of your Inpatient Hospital surgical stay.

Partial Hospitalization Treatment Program

Benefits for Covered Services received in a Partial Hospitalization Treatment Program will be provided at the payment level specified for Inpatient treatment of Mental Illness and Inpatient Substance Abuse Rehabilitation Treatment in the SPECIAL CONDITIONS AND PAYMENT section of this Certificate.

Coordinated Home Care Program

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

BENEFIT PAYMENT FOR INPATIENT HOSPITAL COVERED SERVICES

After you have met your deductible, benefits will be provided at 80% of the Hospital's Eligible Charge when you receive Inpatient Covered Services in a Participating Hospital or in a Plan Program of a Participating Hospital. If you are in a private room, benefits will be limited by the Hospital's rate for its most common type of room with two or more beds.

When you receive Inpatient Covered Services in a Non-Participating Hospital or in a Plan Program of a Non-Participating Hospital, benefits will be provided at 60% of the Hospital's Eligible Charge, after you have met your deductibles. If you are in a private room, benefits will be limited by the Hospital's rate for its most common type of room with two or more beds.

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

Benefits for an Inpatient Hospital admission to a Non-Plan or Non-Participating Hospital resulting from Emergency Accident Care or Emergency Medical Care will be provided at the same payment level which you would have received had you been in a Participating Hospital for that portion of your Inpatient Hospital stay during which your condition is reasonably determined by Blue Cross and Blue Shield to be life threatening and therefore not permitting your safe transfer to a Participating Hospital or other Participating Provider.

Benefits for an Inpatient Hospital admission to a Non-Plan or Non-Participating Hospital resulting from Emergency Accident Care or Emergency Medical Care will be provided at the Non-Participating or Non-Plan Hospital payment level (depending on the type of Provider) for that portion of your Inpatient Hospital stay during which your condition is reasonably determined by Blue Cross and Blue Shield as not being life threatening and therefore permitting your safe transfer to a Participating Hospital or other Participating Provider.

In order for you to continue to receive benefits at the Participating Hospital payment level following an emergency admission to a Non-Plan or Non-Participating Hospital, you must transfer to a Participating Hospital or other Participating Provider as soon as your condition is no longer life threatening.

OUTPATIENT HOSPITAL COVERED SERVICES

The following are Covered Services when you receive them from a Hospital as an Outpatient.

RIDER TO THE POLICY

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

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

A. Policy Year

The following is added to your Policy:

POLICY YEAR

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

B. Effective Date

For Policies in effect before March 23, 2010, this Rider is effective January 1, 2011.

C. Dependent Coverage

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

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

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

The following is added to your Policy:

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

E. Rescissions

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

RESCISSION OF COVERAGE

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

At any time when Blue Cross and Blue Shield is entitled to rescind coverage already in force, Blue Cross and Blue Shield may at its option make an offer to reform the Policy already in force. This reformation could include, but not be limited to, the addition of exclusion riders, and a

change in the rating category/level. In the event of reformation, the Policy will be reissued retroactive in the form it would have been issued had the misstated or omitted information been known at the time of application. Please refer to the appeals sections of your Policy for your appeal rights concerning rescission and/or reformation.

F. Lifetime Maximums

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

The lifetime dollar maximum mentioned in your Policy for Temporomandibular Joint Dysfunction and Related Disorders is deleted in its entirety.

G. Grandfathered Health Plan Disclosure

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

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

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

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

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

Jeffrey R. Tikkanen
President Retail Markets
Blue Cross and Blue Shield of Illinois

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

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

A. DEFINITIONS SECTION

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

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

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

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

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

B. HOSPITAL BENEFIT SECTION

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

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

C. PHYSICIAN BENEFIT SECTION

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

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

D. SPECIAL CONDITIONS AND PAYMENTS

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

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

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

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

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

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

b. **HABILITATIVE SERVICES**

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

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

c. **ROUTINE MAMMOGRAMS**

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

— one baseline mammogram for women age 35-39

— an annual mammogram for women age 40 or older

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

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

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

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

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

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

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

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

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

E. EXCLUSIONS-WHAT IS NOT COVERED

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

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

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

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

3. The following exclusion is added:

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

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

Attest:

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

Secretary

President

RIDER TO THE POLICY

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

BlueCross BlueShield
of Illinois

Notice of Information Practices

HEALTH CARE SERVICE CORPORATION
A MUTUAL LEGAL RESERVE COMPANY

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

Collection of Information

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

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

Circumstances of Disclosures by HCSC

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

- We might use an unaffiliated organization or person to perform a professional, business or insurance function for us. If, for example, we hired an independent organization to assist in the administration of a group insurance plan of which you are a participant, information relating to your insurance coverage would be disclosed to that organization in order for it to adequately perform its function. This would also be the case with respect to any organization or person which performs a professional, business or insurance function for us.
- We may disclose information concerning your coverage to HCSC agents and brokers in order to provide you with adequate service, including the updating and improvement of your insurance program.
- We may disclose information to other insurance institutions, agents, insurance-support organizations or self-insurers, which is necessary (a) to prevent criminal activity, fraud, material misrepresentation or material non-disclosure in connection with insurance transactions, or (b) for either HCSC or such company to perform its function in connection with an insurance transaction involving you or a member of your family insured under your coverage. For example, if you are a participant in an HCSC group health insurance plan, and if you, your spouse or dependents are insured under other group plans, the companies involved may be required to share claims information pursuant to coordination of benefits provisions in their respective policies. The object, of course, is to make sure that you receive total benefits from all companies no greater in amount than the cost of health care received.
- We may disclose information to the Illinois Insurance regulatory authority in connection with its regulation of our business.
- We may disclose information to a law enforcement or governmental authority to protect our interests in preventing or prosecuting the perpetration of a fraud upon us, or if we reasonably believe that illegal activities have been conducted. We will also disclose information where permitted or required by law to do so.
- Various industry and professional organizations conduct scientific and actuarial research studies to learn more about the risk experience of insureds. Other organizations conduct studies relating to medical research. These studies are purely scientific in nature, never identify individuals in their reports, and always maintain information provided in a highly confidential manner. When asked to provide information to such organizations, we ordinarily will do so because the results of such studies are of benefit to our customers and to the public at large. You will not be individually identified in any report that results from the research, and material that we give to the person or organization performing the research will be returned to us or destroyed when it is no longer needed.
- If you are covered under an HCSC group policy, we may disclose information as is reasonably necessary to the group for purposes of administration of the group policy and to permit the group to audit, review and evaluate the performance of HCSC under the group policy.
- We are sometimes approached by persons or organizations who are interested in the opportunity to market products or services to our customers. When this happens, we may provide some limited information. However, if we want to give information to persons not affiliated with us, we will give you an opportunity to indicate to us that you do not want information to be disclosed for this purpose. We will give information to HCSC affiliates so that our customers may be made aware of the insurance products and services offered by affiliates of HCSC.

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

Your Right to Access to Personal Information

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

1. If you have any questions about what information we may have on file about you, please write us at the address indicated at the end of this notice. We will need your complete name, address, date of birth and all policy numbers under which you are insured. Tell us what information you would like to receive. Within 30 days of our receipt of your written request, we will:
   a. inform you of the nature and substance of the recorded personal information in writing, by telephone or by other oral communication;
   b. permit you to see and copy, in person (by appointment only) the recorded personal information which applies to you or provide you with copies of this information by mail, whichever you prefer. If such information is in coded form, an accurate translation i plain language will be provided to you in writing;
   c. inform you of the persons, if recorded, to which the personal information has been disclosed within two years of your request. I the identities have not been recorded, we will provide you with the names of those insurance institutions, agents, insurance-support organizations or other persons to whom such information is normally disclosed;
   d. provide you with a summary of the procedures by which you may request correction or deletion of recorded personal information.
2. Medical-record information provided by a medical-professional will be supplied, along with the source of information, to you; or you will be notified that it has been disclosed to a medical professional you have designated and who is licensed to provide medical care with respect to the condition to which the information applies.
3. We may charge you a reasonable fee to cover the costs incurred in providing you with a copy of recorded personal information. If the information applies to reasons for an adverse underwriting decision, there will be no charge.
4. In some circumstances, our obligations to you regarding access to recorded personal information exists to the extent that the information is collected and maintained in connection with an insurance transaction. These rights do not extend to information abo you that relates to and is collected in connection with or in reasonable anticipation of a claim or civil or criminal proceeding.

Your Right to Correct Personal Information

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

1. Within 30 days of receiving your written request to correct, amend or delete any recorded personal information we have, we will:
   a. correct, amend or delete the portion of the recorded personal information in dispute, or
   b. notify you of our refusal to make the correction, amendment or deletion, the reasons for the refusal and your right to file a protest statement.
2. If the recorded personal information is corrected, amended or deleted, you will be notified in writing and this information will be furnished to:
   a. any person you have designed who may have, within the preceding 2 years, received such recorded personal information;
   b. any insurance-support organization whose primary source of personal information is insurance institutions, if it has systematically received such recorded personal information from us within the preceding 7 years, unless the insurance-support organization no longer maintains recorded personal information about you;
   c. any insurance-support organization that furnished the personal information that has been corrected, amended or deleted.
3. If you disagree with a refusal to correct, amend or delete recorded personal information, you may file a:
   a. concise statement setting forth what you think is the correct, relevant or fair information, and
   b. concise statement of the reasons why you disagree with the refusal to correct, amend or delete recorded personal information.
4. If you file either of the statements described above, we will:
   a. file the statement with the disputed personal information and provide a means by which anyone reviewing the disputed person information will be made aware of the statement and have access to it;
   b. in any subsequent disclosure of the recorded personal information that is the subject of disagreement, clearly identify the information in dispute and provide the statements along with the recorded personal information being disclosed;
   c. furnish the statement to any of the three categories of persons and organizations covered in the preceding point "2."
5. Your rights to correct, amend or delete recorded personal information exist to the extent that the information is collected and maintained in connection with an insurance transaction. These rights do not extend to information about you that relates to and is collected in connection with or in reasonable anticipation of a claim or civil or criminal proceeding.

Your Privacy is Our Concern

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

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

RIDER TO THE POLICY

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

DEFINITIONS SECTION

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Attest:

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

Deborah Dorman-Rodriguez
Secretary

Patricia A. Heminway Hall
President

RIDER TO THE POLICY TO IMPLEMENT
ILLINOIS WELLNESS COVERAGE

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

The changes below are effective June 1, 2010.

GENERAL PROVISIONS

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

VALUE BASED DESIGN PROGRAMS

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

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

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

Jeffrey R. Tikkanen
President, Retail Markets

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.