

HMO ILLINOIS
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BlueCross BlueShield of Illinois

SAMPLE COPY

Your Health Care Benefit Program

A message from

BLUE CROSS AND BLUE SHIELD

Your Group has entered into an agreement with us (Blue Cross and Blue Shield of Illinois, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association) to provide you with this HMO Illinois health care benefit program. In this Certificate, we refer to our company as the “Plan” and we refer to your employer, association or trust as the “Group”.

YOUR PRIMARY CARE PHYSICIAN OR WOMAN’S PRINCIPAL HEALTH CARE PROVIDER IS AN INDEPENDENT CONTRACTOR, NOT AN EMPLOYEE OR AGENT OF YOUR BLUE CROSS HMO. YOUR PRIMARY CARE PHYSICIAN OR WOMAN’S PRINCIPAL HEALTH CARE PROVIDER RENDERS AND COORDINATES YOUR MEDICAL CARE. YOUR BLUE CROSS HMO IS YOUR BENEFIT PROGRAM, NOT YOUR HEALTH CARE PROVIDER.

We suggest that you read this entire Certificate very carefully. We hope that any questions that you might have about your coverage will be answered here.

THIS CERTIFICATE REPLACES ANY PREVIOUS CERTIFICATES THAT YOU MAY HAVE BEEN ISSUED BY THE PLAN.

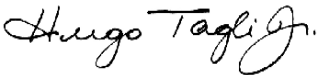
If you have any questions once you have read this Certificate, talk to your Group Administrator or call us at your local Blue Cross and Blue Shield office. It is important to all of us that you understand the protection this coverage gives you.

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 and CEO



Hugo Tagli Jr.
Secretary

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BENEFIT HIGHLIGHTS

Your health care benefits are highlighted below. However, it is necessary to read this entire Certificate to obtain a complete description of your benefits. It is important to remember that benefits will only be provided for services or supplies that have been ordered by your Primary Care Physician or Woman's Principal Health Care Provider (unless specified otherwise in this Certificate).

PHYSICIAN BENEFITS

— Your Cost for Covered Services (unless specified otherwise below)	None
— Your Cost for Outpatient Office Visits	\$15 per Visit
— Your Cost for Outpatient Specialist Physician Visits	\$25 per Visit
— Your Cost for Outpatient Psychiatric Care	\$15 per Visit
— Limit on Number of Outpatient Psychiatric Care Visits	30 Visits per Calendar Year
— Your Cost for Outpatient Rehabilitative Therapy	\$15 per Treatment
— Limit on Number of Outpatient Rehabilitative Therapy Treatments	60 Treatments per Calendar Year

HOSPITAL BENEFITS

— Your Deductible	\$100 per Inpatient Admission
— Limit on Number of Inpatient Days for Mental Illness Treatment	30 Days per Calendar Year
— Your Cost for Outpatient Surgery	\$50 per Visit
— Your Cost for All Other Outpatient Covered Services	None

SUPPLEMENTAL BENEFITS

— Your Cost for Covered Services	None
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EMERGENCY CARE BENEFITS

- Your Cost for an In-Area
Emergency \$75 Emergency Room Copayment
(waived if admitted to Hospital as
an Inpatient immediately following
emergency treatment)
- Your Cost for an Out-of-Area
Emergency \$75 Emergency Room Copayment
(waived if admitted to Hospital as
an Inpatient immediately following
emergency treatment)
- Your Cost for Emergency
Ambulance Transportation None

CHEMICAL DEPENDENCY TREATMENT BENEFITS

- Your Deductible for
Inpatient Chemical
Dependency Treatment \$100 per Inpatient Admission
- Limit on Number of Inpatient
Days for Chemical
Dependency Treatment 30 Days per Calendar Year
- Your Cost for Outpatient
Chemical Dependency
Treatment \$15 per Visit
- Limit on Number of
Outpatient Chemical
Dependency Treatment Visits 30 Visits per Calendar Year

Refer to the OTHER THINGS YOU SHOULD KNOW section of your Certificate for information regarding Covered Services Expense Limitation

OUTPATIENT PRESCRIPTION DRUG PROGRAM BENEFITS

- Your Cost for Prescription Drugs Obtained from a Prescription
Drug Provider Participating in the **34-Day Supply**
Prescription Drug Program:
 - Generic Drugs \$10 per Prescription
 - Formulary
Brand-name Drugs \$20 per Prescription
 - Non-Formulary
Brand-name Drugs \$35 per Prescription
 - Self-Injectable Drugs
other than Insulin
and Infertility Drugs \$50 per Prescription

- Diabetic Supplies None
- Your Cost for Prescription Drugs Obtained from a Prescription Drug Provider Not Participating in the **34-Day Supply** Prescription Drug Program:
 - For drugs purchased within Illinois:
No benefits will be provided for drugs purchased from a Non-Participating Prescription Drug Provider.
 - For drugs purchased outside Illinois:
The appropriate Copayment(s) indicated above plus any difference between the Participating Provider's Charge and the Non-Participating Provider's Charge for drugs prescribed for emergency conditions.
- Your Cost for Prescription Drugs Obtained from a Prescription Drug Provider Participating in the **90-Day Supply** Prescription Drug Program:
 - Generic Drugs \$20 per Prescription
 - Formulary Brand-name Drugs \$40 per Prescription
 - Non-Formulary Brand-name Drugs \$70 per Prescription
 - Self-Injectable Drugs other than Insulin and Infertility Drugs \$50 per Prescription
 - Diabetic Supplies None
- Your Cost for Prescription Drugs Obtained from a Prescription Drug Provider Not Participating in the **90-Day Supply** Prescription Drug Program:
 - No benefits will be provided for a Prescription Drug Provider not participating in the 90-day supply program.

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ELIGIBILITY

The benefits described in this Certificate will be provided to persons who:

- Meet the definition of an Eligible Person as specified in the Group Policy;
- Have applied for this coverage;
- Have received a Blue Cross and Blue Shield identification card;
- Live within the Plan's service area. (Contact your Group or Member Services at 1-800-892-2803 for information regarding service area.); and,
- If Medicare eligible, have both Part A and B coverage.

REPLACEMENT OF DISCONTINUED GROUP COVERAGE

When your Group initially purchases this coverage, if such coverage is purchased as replacement of coverage under another carrier's group policy, persons who are Totally Disabled on the effective date of this coverage but who otherwise meet the definition of an Eligible Person under this coverage and who were covered under the prior group policy will be eligible for coverage under this Certificate.

Totally Disabled dependents of an Eligible Person will be considered eligible dependents under this Certificate provided such dependents meet the description of an eligible family member as specified below under the heading Family Coverage. Dependent children who have reached the limiting age of this Certificate will be considered eligible dependents under this Certificate if they were covered under the prior group policy and, because of a handicapped condition, are incapable of self sustaining employment and are dependent upon the Eligible Person or other care providers for lifetime care and supervision.

Such Totally Disabled persons will be entitled to all of the benefits of this Certificate. Benefits will be coordinated with benefits under the prior group policy and the prior group policy will be considered the primary coverage for all services rendered in connection with the disability when no coverage is available under this Certificate due to the absence of coverage in this Certificate. The provisions of this Certificate regarding Primary Care Physician referral remain in effect for such Totally Disabled persons.

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

Under Family Coverage, your health care expenses and those of your enrolled spouse and your (and/or your spouse's) unmarried children who are under the limiting age specified on the Benefit Highlights page will be covered. A Domestic Partner and his or her children are also eligible dependents. All of the provisions of this Certificate that pertain to a spouse also apply to a Domestic Partner.

Coverage for unmarried children will end on the last day of the calendar month in which the limiting age birthday falls.

If you have Family Coverage, newborn children will be covered from the moment of birth as long as the Plan receives notice of the birth within 31 days of the birth. Your Group Administrator can tell you how to submit the proper notice.

Children who are under your legal guardianship or who are in your custody under an interim court order prior to finalization of adoption or placement of adoption vesting temporary care, whichever comes first, will be covered. In addition, if you have children for whom you are required by court order to provide health care coverage, those children will be covered.

Any children who are incapable of self-sustaining employment and are dependent upon you or other care providers for lifetime care and supervision because of a handicapped condition occurring prior to reaching the limiting age will be covered regardless of age as long as they were covered prior to reaching the limiting age specified on the Benefit Highlights page.

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

MEDICARE ELIGIBLE COVERED PERSONS

A series of federal laws collectively referred to as the “Medicare Secondary Payer” (MSP) laws regulate the manner in which certain employers may offer group health care coverage to Medicare eligible employees, spouses, and in some cases, dependent children.

The statutory requirements and rules for MSP coverage vary depending on the basis for Medicare and employer group health plan (“GHP”) coverage, as well as certain other factors, including the size of the employers sponsoring the GHP. In general, Medicare pays secondary to the following:

1. GHPs that cover individuals with end-stage renal disease (“ESRD”) during the first 30 months of Medicare eligibility or entitlement. This is the case regardless of the number of employees employed by the employer or whether the individual has “current employment status.”
2. In the case of individuals age 65 or over, GHPs of employers that employ 20 or more employees if that individual or the individual’s spouse (of any age) has “current employment status.” If the GHP is a multi-employer or multiple employer plan, which has at least one participating employer that employs 20 or more employees, the MSP rules apply even with respect to employers of fewer than 20 employees (unless the plan elects the small employer exception under the statute).
3. In the case of disabled individuals under age 65, GHPs of employers that employ 100 or more employees, if the individual or a member of the individual’s family has “current employee status.” If the GHP is a multi-employer or multiple employer plan, which has at least one participating employer that employs 100 or more employees, the

MSP rules apply even with respect to employers of fewer than 100 employees.

Please see your employer or Group Administrator if you have any questions regarding the ESRD Primary Period or any other provisions of the MSP laws and their application to you, your spouse or your dependents.

Your MSP Responsibilities

In order to assist your employer in complying with MSP laws, it is very important that you promptly and accurately complete any requests for information from the Plan and/or your employer regarding the Medicare eligibility of you, your spouse and covered dependent children. In addition, if you, your spouse or covered dependent child becomes eligible for Medicare, or has Medicare eligibility terminated or changed, please contact your employer or your group administrator promptly to ensure that your claims are processed in accordance with applicable MSP laws.

YOUR IDENTIFICATION CARD

You will receive an identification (ID) card from the Plan. Your ID card contains your identification number, the name of the Participating IPA/Participating Medical Group that you have selected and the phone number to call in an emergency. Always carry your ID card with you.

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

You can change from Individual to Family Coverage or add dependents to your Family Coverage because of any of the following events:

- Marriage.
- Birth, adoption or placement for adoption of a child.
- Obtaining legal guardianship of a child.
- The establishment of a Domestic Partnership.
- Loss of eligibility for other health coverage for you or your dependent if:
 - a. The other coverage was in effect when you were first eligible to enroll for this coverage;
 - b. The other coverage is not terminating for cause (such as failure to pay premiums or mailing a fraudulent claim); and
 - c. Where required, you stated in writing that coverage under another group health plan or other health insurance coverage was the reason for declining enrollment in this coverage.

This includes, but is not limited to, loss of coverage due to:

- a. Legal separation, divorce, cessation of dependent status, death, termination of employment, or reduction in number of hours of employment;

- b. Moving out of the HMO service area;
 - c. Reaching a lifetime limit on all benefits in another group health plan; or
 - d. Another group health plan no longer offering any benefits to the class of similarly situated individuals that includes you or your dependent.
- Termination of employer contributions towards your or your dependent's other coverage.
 - Exhaustion of COBRA continuation coverage or state continuation coverage.

WHEN COVERAGE BEGINS

Your Family Coverage or the coverage for your additional dependent(s) will be effective from the date of the event if you apply for this change within 31 days of any of the following events:

- Marriage.
- Birth, adoption or placement for adoption of a child.
- Obtaining legal guardianship of a child.
- The establishment of a Domestic Partnership.

You can get the application form from your Group Administrator. However, an application to add a newborn to Family Coverage is not necessary if an additional premium is not required. Please notify your Group Administrator so that your membership records can be adjusted.

Your Family Coverage or the coverage for your additional dependent(s) will be effective from the date you apply for coverage if you apply within 31 days of any of the following events:

- Loss of eligibility for other coverage for you or your dependent, except for loss of coverage due to reaching a lifetime limit on all benefits.
- Termination of employer contributions towards your or your dependent's other coverage.
- Exhaustion of COBRA continuation or state continuation coverage.

If coverage is lost in another group health plan because a lifetime limit on all benefits is reached under that coverage and you apply for Family Coverage or to add dependents within 31 days after a claim is denied due to reaching the lifetime limit, your Family Coverage or the coverage for your additional dependents will be effective from the date your claim was denied.

LATE APPLICANTS

If you do not apply for Family Coverage or to add dependents within the allotted time, you will have to wait until your Group's annual open enrollment period to do so. Your Family Coverage or the coverage for your additional dependents will then be effective on the first day of the month following the open enrollment peri-

od. Benefits will not be provided for any treatment of an illness or injury to a newborn child unless you have Family Coverage. (Remember, you must add the newborn child within 31 days of the date of birth.)

CHANGING FROM FAMILY TO INDIVIDUAL COVERAGE

You can apply to change from Family to Individual Coverage at any time. Your Group Administrator will give you the application and tell you the date that the change will be effective. Premiums will be adjusted accordingly.

TERMINATION OF COVERAGE

You will no longer be entitled to the health care benefits described in this Certificate when:

- You no longer meet the previously stated description of an Eligible Person;
or
- The entire coverage of your Group terminates.

If one of your dependents becomes ineligible, his/her coverage will end as of the date the event occurs which makes him/her ineligible (for example, date of marriage, date of divorce) or a date determined by your Group. Coverage for a dependent child who reaches the limiting age will end as specified above under the heading "Family Coverage."

Your coverage (and the coverage of all of your family members) will be terminated, at the Plan's option, for failure to pay any required premium or charge, or for fraud or material misrepresentation in enrollment or in the use of services or facilities.

Benefits will not be provided for any services or supplies received after the date your coverage terminates under this Certificate unless specifically stated otherwise in the benefit sections of this Certificate or below under the heading Extension of Benefits in Case of Discontinuance of Coverage. However, termination of your coverage will not affect your benefits for any services or supplies that you received prior to your termination date.

Termination of your Group's Policy automatically terminates your coverage under this Certificate. It is your Group's responsibility to inform you of the termination of the Group Policy but your coverage will be terminated regardless of whether or not such notice is given.

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

Extension of Benefits in Case of Discontinuance of Coverage

If you are Totally Disabled at the time your entire Group terminates, benefits will be provided for (and limited to) the Covered Services described in this Certificate which are related to the disability. Benefits will be provided when no coverage is available under the succeeding carrier's policy whether due to the absence of coverage in the policy or lack of required Creditable Coverage for a preexisting

condition. Benefits will be provided for a period of no more than 12 months from the date of termination. These benefits are subject to all of the terms and conditions of this Certificate including, but not limited to, the requirements regarding Primary Care Physician referral. It is your responsibility to notify the Plan, and to provide, when requested by the Plan, written documentation of your disability. This extension of benefits does not apply to the benefits provided in the following Benefit Section(s) of this Certificate: Outpatient Prescription Drug Program.

CONTINUATION COVERAGE RIGHTS UNDER COBRA

NOTE: Certain employers may not be affected by CONTINUATION OF COVERAGE AFTER TERMINATION (COBRA). See your employer or Group Administrator should you have any questions about COBRA.

Introduction

You are receiving this notice because you have recently become covered under your employer's group health plan (the Plan). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.**

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage.

For additional information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

What Is COBRA Continuation Coverage

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced; or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse’s hours of employment are reduced;
- Your spouse’s employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes enrolled in Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happen:

- The parent-employee dies;
- The parent-employee’s hours of employment are reduced;
- The parent-employee’s employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes enrolled in Medicare benefits (under Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a “dependent child.”

If the Plan provides health care coverage to retired employees, the following applies: Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to your employer, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary with respect to the bankruptcy. The retired employee’s spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When Is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, in the event of retired employee health coverage, commencement of a proceeding in bankruptcy with respect to the employer, or the employee’s becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. Contact your employer and/or COBRA Administrator for procedures for this notice, including a description of any required information or documentation.

How Is COBRA Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to 36 months.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability Extension of 18-Month Period of Continuation Coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. Contact your employer and/or the COBRA Administrator for procedures for this notice, including a description of any required information or documentation.

Second Qualifying Event Extension of 18-Month Period of Continuation Coverage

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights, should be addressed to your Plan Administrator. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U. S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan Contact Information

Contact your employer for the name, address and telephone number of the party responsible for administering your COBRA continuation coverage.

COVERAGE AFTER TERMINATION (Illinois State Laws)

The purpose of this section of your Certificate is to explain the options available for continuing your coverage after termination, as it relates to Illinois state legislation. The provisions which apply to you will depend upon your status at the time of termination. The provisions described in Article A will apply if you are the Eligible Person (as specified in the Group Policy) at the time of termination. The provisions described in Article B will apply if you are the spouse of a retired Eligible Person and are at least 55 years of age or the former spouse of an Eligible Person who has died or from whom you have been divorced. The provisions described in Article C will apply if you are the dependent child of an Eligible Person who has died or if you have reached the limiting age under this Certificate and not eligible to continue coverage as provided under Article B.

Your continued coverage under this Certificate will be provided only as specified below. Therefore, after you have determined which Article applies to you, please read the provisions very carefully.

ARTICLE A: Continuation of coverage if you are the Eligible Person

If an Eligible Person's coverage under this Certificate should terminate because of termination of employment or membership or because of a reduction in hours below the minimum required for eligibility, an Eligible Person will be entitled to continue the Hospital, Physician and Supplemental coverage provided under this Certificate for himself/herself and his/her eligible dependents (if he/she had Family Coverage on the date of termination). However, this continuation of coverage option is subject to the following conditions:

1. Continuation of coverage will be available to you only if you have been continuously covered under this Certificate for at least 3 months prior to your termination date or reduction in hours below the minimum required for eligibility.
2. Continuation of coverage will not be available to you if: (a) you are covered by Medicare or (b) you have coverage under any other health care program which provides group hospital, surgical or medical coverage and under which you were not covered immediately prior to such termination or reduction in hours below the minimum required for eligibility, or (c) you decide to become a member of the Plan on a "direct pay" basis.
3. If you decide to become a member of the Plan on a "direct pay" basis, you may not, at a later date, elect the continuation of coverage option under this Certificate. Upon termination of the continuation of coverage period as explained in paragraph 6 below, you may exercise the Conversion Privilege explained in the ELIGIBILITY section of this Certificate.
4. Upon termination of employment or membership or reduction in hours below the minimum required for eligibility, your Group will provide you with written notice of this option to continue your coverage. If you decide to continue your coverage, you must notify your Group, in writing, no later than 10 days after your coverage has terminated or reduction in hours below the minimum required for eligibility or 10 days after the date you received notice from your Group of this option to continue coverage. However, in no event will you be entitled to your continuation of coverage option more than 60 days after your termination or reduction in hours below the minimum required for eligibility.
5. If you decide to continue your coverage under this Certificate, you must pay your Group on a monthly basis, in advance, the total charge required by the Plan for your continued coverage, including any portion of the charge previously paid by your Group. Payment of this charge must be made to the Plan (by your Group) on a monthly basis, in advance, for the entire period of your continuation of coverage under this Certificate.
6. Continuation of coverage under this Certificate will end on the date you become eligible for Medicare, become a member of the Plan on a "direct pay" basis or become covered under another health care program (which you did

not have on the date of your termination or reduction in hours below the minimum required for eligibility) which provides group hospital, surgical or medical coverage. However, your continuation of coverage under this Certificate will also end on the first to occur of the following:

- a. Nine months after the date the Eligible Person's coverage under this Certificate would have otherwise ended because of termination of employment or membership or reduction in hours below the minimum required for eligibility.
- b. If you fail to make timely payment of required charges, coverage will terminate at the end of the period for which your charges were paid.
- c. The date on which the Group Policy is terminated. However, if this Certificate is replaced by similar coverage under another group policy, the Eligible Person will have the right to become covered under the new coverage for the amount of time remaining in the continuation of coverage period.

ARTICLE B: Continuation of Coverage if you are the former spouse of an Eligible Person or spouse of a retired Eligible Person

If the coverage of the spouse of an Eligible Person should terminate because of the death of the Eligible Person, a divorce from the Eligible Person, or the retirement of an Eligible Person, the former spouse or retired Eligible Person's spouse if at least 55 years of age, will be entitled to continue the coverage provided under this Certificate for himself/herself and his/her eligible dependents (if Family Coverage is in effect at the time of termination). However, this continuation of coverage option is subject to the following conditions:

1. Continuation will be available to you as the former spouse of an Eligible Person or spouse of a retired Eligible Person only if you provide the employer of the Eligible Person with written notice of the dissolution of marriage, the death or retirement of the Eligible Person within 30 days of such event.
2. Within 15 days of receipt of such notice, the employer of the Eligible Person will give written notice to the Plan of the dissolution of your marriage to the Eligible Person, the death of the Eligible Person or the retirement of the Eligible Person as well as notice of your address. Such notice will include the Group number and the Eligible Person's identification number under this Certificate. Within 30 days of receipt of notice from the employer of the Eligible Person, the Plan will advise you at your residence, by certified mail, return receipt requested, that your coverage and your covered dependents under this Certificate may be continued. The Plan's notice to you will include the following:
 - a. a form for election to continue coverage under this Certificate.
 - b. notice of the amount of monthly charges to be paid by you for such continuation of coverage and the method and place of payment.
 - c. instructions for returning the election form within 30 days after the date it is received from the Plan.

3. In the event you fail to provide written notice to the Plan within the 30 days specified above, benefits will terminate for you on the date coverage would normally terminate for a former spouse or spouse of a retired Eligible Person under this Certificate as a result of the dissolution of marriage, the death or the retirement of the Eligible Person. Your right to continuation of coverage will then be forfeited.
4. If the Plan fails to notify you as specified above, all charges shall be waived from the date such notice was required until the date such notice is sent and benefits shall continue under the terms of this Certificate from the date such notice is sent, except where the benefits in existence at the time of the Plan's notice was to be sent are terminated as to all Eligible Persons under this Certificate.
5. If you have not reached age 55 at the time your continued coverage begins, the monthly charge will be computed as follows:
 - a. an amount, if any, that would be charged to you if you were an Eligible Person, with Individual or Family Coverage, as the case may be, plus
 - b. an amount, if any, that the employer would contribute toward the charge if you were the Eligible Person under this Certificate.

Failure to pay the initial monthly charge within 30 days after receipt of notice from the Plan as required in this Article will terminate your continuation benefits and the right to continuation of coverage.

6. If you have reached age 55 at the time your continued coverage begins, the monthly charge will be computed for the first 2 years as described above. Beginning with the third year of continued coverage, an additional charge, not to exceed 20% of the total amounts specified in (5) above will be charged for the costs of administration.
7. Termination of Continuation of Coverage:

If you have not reached age 55 at the time your continued coverage begins, your continuation of coverage shall end on the first to occur of the following:

- a. if you fail to make any payment of charges when due (including any grace period specified in the Group Policy).
- b. on the date coverage would otherwise terminate under this Certificate if you were still married to the Eligible Person; however, your coverage shall not be modified or terminated during the first 120 consecutive days following the Eligible Person's death or entry of judgment dissolving the marriage existing between you and the Eligible Person, except in the event this entire Certificate is modified or terminated.
- c. the date on which you remarry.
- d. the date on which you become an insured employee under any other group health plan.

- e. the expiration of 2 years from the date your continued coverage under this Certificate began.
8. If you have reached age 55 at the time your continued coverage begins, your continuation of coverage shall end on the first to occur of the following:
 - a. if you fail to make any payment of charges when due (including any grace period specified in the Group Policy).
 - b. on the date coverage would otherwise terminate, except due to the retirement of the Eligible Person under this Certificate if you were still married to the Eligible Person; however, your coverage shall not be modified or terminated during the first 120 consecutive days following the Eligible Person's death, retirement or entry of judgment dissolving the marriage existing between you and the Eligible Person, except in the event this entire Certificate is modified or terminated.
 - c. the date on which you remarry.
 - d. the date on which you become an insured employee under any other group health plan.
 - e. the date upon which you reach the qualifying age or otherwise establish eligibility under Medicare.
9. If you exercise the right to continuation of coverage under this Certificate, you shall not be required to pay charges greater than those applicable to any other Eligible Person covered under this Certificate, except as specifically stated in these provisions.
10. Upon termination of your continuation of coverage, you may exercise the privilege to become a member of the Plan on a "direct pay" basis as specified in the Conversion Privilege of the ELIGIBILITY SECTION of this Certificate.
11. If this entire Certificate is cancelled and another insurance company contracts to provide group health insurance at the time your continuation of coverage is in effect, the new insurer must offer continuation of coverage to you under the same terms and conditions described in this Certificate.

ARTICLE C: Continuation of Coverage if you are the dependent child of an Eligible Person

If the coverage of a dependent child should terminate because of the death of the Eligible Person and the dependent child is not eligible to continue coverage under ARTICLE B or the dependent child has reached the limiting age under this Certificate, the dependent child will be entitled to continue the coverage provided under this Certificate for himself/herself. However, this continuation of coverage option is subject to the following conditions:

1. Continuation will be available to you as the dependent child of an Eligible Person only if you, or a responsible adult acting on your behalf as the dependent child, provide the employer of the Eligible Person with written notice of the death of the Eligible Person within 30 days of the date the coverage terminates.

2. If continuation of coverage is desired because you have reached the limiting age under this Certificate, you must provide the employer of the Eligible Person with written notice of the attainment of the limiting age within 30 days of the date the coverage terminates.
3. Within 15 days of receipt of such notice, the employer of the Eligible Person will give written notice to the Plan of the death of the Eligible Person or of the dependent child reaching the limiting age, as well as notice of the dependent child's address. Such notice will include the Group number and the Eligible Person's identification number under this Certificate. Within 30 days of receipt of notice from the employer of the Eligible Person, the Plan will advise you at your residence, by certified mail, return receipt requested, that your coverage under this Certificate may be continued. The Plan's notice to you will include the following:
 - a. a form for election to continue coverage under this Certificate.
 - b. notice of the amount of monthly charges to be paid by you for such continuation of coverage and the method and place of payment.
 - c. instructions for returning the election form within 30 days after the date it is received from the Plan.
4. In the event you, or the responsible adult acting on your behalf as the dependent child, fail to provide written notice to the Plan within the 30 days specified above, benefits will terminate for you on the date coverage would normally terminate for a dependent child of an Eligible Person under this Certificate as a result of the death of the Eligible Person or the dependent child attaining the limiting age. Your right to continuation of coverage will then be forfeited.
5. If the Plan fails to notify you as specified above, all charges shall be waived from the date such notice was required until the date such notice is sent and benefits shall continue under the terms of this Certificate from the date such notice is sent, except where the benefits in existence at the time of the Plan's notice was to be sent are terminated as to all Eligible Persons under this Certificate.
6. The monthly charge will be computed as follows:
 - a. an amount, if any, that would be charged to you if you were an Eligible Person, plus
 - b. an amount, if any, that the employer would contribute toward the charge if you were the Eligible Person under this Certificate.

Failure to pay the initial monthly charge within 30 days after receipt of notice from the Plan as required in this Article will terminate your continuation benefits and the right to continuation of coverage.

7. Continuation of Coverage shall end on the first to occur of the following:
 - a. if you fail to make any payment of charges when due (including any grace period specified in the Group Policy).

- b. on the date coverage would otherwise terminate under this Certificate if you were still an eligible dependent child of the Eligible Person.
 - c. the date on which you become an insured employee, after the date of election, under any other group health plan.
 - d. the expiration of 2 years from the date your continued coverage under this Certificate began.
8. If you exercise the right to continuation of coverage under this Certificate, you shall not be required to pay charges greater than those applicable to any other Eligible Person covered under this Certificate, except as specifically stated in these provisions.
 9. Upon termination of your continuation of coverage, you may exercise the privilege to become a member of the Plan on a “direct pay” basis as specified in the Conversion Privilege of the ELIGIBILITY SECTION of this Certificate.
 10. If this entire Certificate is cancelled and another insurance company contracts to provide group health insurance at the time your continuation of coverage is in effect, the new insurer must offer continuation of coverage to you under the same terms and conditions described in this Certificate.

Conversion

In addition to the option of continuing your Group coverage after termination, you have the option of converting your Group coverage to direct-payment coverage. This option, conversion privilege, is explained below.

If you choose to convert your Group coverage to direct-payment coverage, you may not, at a later date, select the continuation of group coverage option. However, the conversion privilege will be available when the continuation of coverage period ends.

CONVERSION PRIVILEGE

If, at the time that your coverage under this Certificate is terminated, you have been covered for at least three months, either as an Eligible Person or a dependent of an Eligible Person, you may convert your coverage to the coverage that the Plan has available for persons who are no longer members of a group.

In order to convert your coverage you should:

- Contact the Plan to get an application.
- Send the application to the Plan within 31 days of the date that your coverage is terminated.

Having done so, you will then be covered by the Plan on an individual “direct-payment” basis. Your converted coverage will be effective from the date that your Group coverage terminates as long as you pay the required premiums when due.

The converted coverage may require copayments and/or deductibles that are different from those of this Certificate. The converted coverage will provide, at minimum, benefits for basic health care services as defined in the HMO Act.

The Plan is not required to offer conversion coverage to you if you no longer live within the service area of a Participating IPA or Participating Medical Group. However, if you have similar benefits under a group arrangement that does not cover pre-existing conditions, and you have a pre-existing condition, you can continue conversion coverage until your pre-existing condition is covered under that group arrangement.

Conversion coverage is not available when your Group terminates its coverage under this Certificate and replaces it with other coverage or when your coverage has been terminated for: failure to pay a required premium or charge; fraud or material misrepresentation in enrollment or in the use of services or facilities.

YOUR PRIMARY CARE PHYSICIAN

YOUR PRIMARY CARE PHYSICIAN OR WOMAN'S PRINCIPAL HEALTH CARE PROVIDER IS AN INDEPENDENT CONTRACTOR, NOT AN EMPLOYEE OR AGENT OF YOUR BLUE CROSS HMO. YOUR PRIMARY CARE PHYSICIAN OR WOMAN'S PRINCIPAL HEALTH CARE PROVIDER RENDERS AND COORDINATES YOUR MEDICAL CARE. YOUR BLUE CROSS HMO IS YOUR BENEFIT PROGRAM, NOT YOUR HEALTH CARE PROVIDER.

At the time that you applied for this coverage, you selected a Participating Individual Practice Association (IPA) and a Primary Care Physician or a Participating Medical Group. If you enrolled in Family Coverage, then members of your family may select a different Participating IPA/Participating Medical Group. You must choose a Primary Care Physician for each of your family members from the selected Participating IPA/Participating Medical Group. In addition, female members also may choose a Woman's Principal Health Care Provider. A Woman's Principal Health Care Provider may be seen for care without referrals from your Primary Care Physician, however your Primary Care Physician and your Woman's Principal Health Care Provider must have a referral arrangement with one another. Contact your Participating IPA/Participating Medical Group, your Primary Care Physician or Woman's Principal Health Care Provider or the Plan for a list of Providers with whom your Primary Care Physician and/or your Woman's Principal Health Care Provider has a referral arrangement.

Your Primary Care Physician and/or your Woman's Principal Health Care Provider is affiliated with or employed by your Participating IPA or Participating Medical Group. Your Primary Care Physician is responsible for coordinating all of your health care needs. In the case of female members, your health care needs may be coordinated by your Primary Care Physician and/or your Woman's Principal Health Care Provider.

TO BE ELIGIBLE FOR THE BENEFITS OF THIS CERTIFICATE, THE SERVICES THAT YOU RECEIVE MUST BE PROVIDED BY OR ORDERED BY YOUR PRIMARY CARE PHYSICIAN OR WOMAN'S PRINCIPAL HEALTH CARE PROVIDER.

To receive benefits for treatment from another Physician or Provider, you must be referred to that Provider by your Primary Care Physician or Woman's Principal Health Care Provider. That referral must be in writing and must specifically state the services that are to be rendered. Benefits will be limited to those specifically stated services.

If you have an illness or injury that needs ongoing treatment from another Physician or Provider, you may apply for a Standing Referral to that Physician or Provider from your Primary Care Physician or Woman's Principal Health Care Provider. Your Primary Care Physician or Woman's Principal Health Care Provider may authorize the Standing Referral which shall be effective for the period necessary to provide the referred services or up to a period of one year.

The only time that you can receive benefits for services not ordered by your Primary Care Physician or Woman's Principal Health Care Provider is when you are

receiving either emergency care or treatment for Chemical Dependency or routine vision examinations. Those benefits are explained in detail in the Emergency Care Benefits, Chemical Dependency Benefits Sections and, for routine vision examinations, Physician Benefits Sections of this Certificate. It is important that you understand the provisions of those sections.

PLEASE NOTE, BENEFITS WILL NOT BE PROVIDED FOR SERVICES OR SUPPLIES THAT ARE NOT LISTED AS COVERED SERVICES IN THIS CERTIFICATE, EVEN IF THEY HAVE BEEN ORDERED BY YOUR PRIMARY CARE PHYSICIAN OR WOMAN'S PRINCIPAL HEALTH CARE PROVIDER.

Changing Your Primary Care Physician or Woman's Principal Health Care Provider

You may change your choice of Primary Care Physician or Woman's Principal Health Care Provider to one of the other Physicians in your Participating IPA or Participating Medical Group by notifying your Participating IPA/Participating Medical Group of your desire to change. Contact your Participating IPA/Participating Medical Group, your Primary Care Physician or Woman's Principal Health Care Provider or the Plan to obtain a list of providers with whom your Primary Care Physician and/or Woman's Principal Health Care Provider have a referral arrangement.

Changing Your Participating IPA/Participating Medical Group

You may change from your Participating IPA/Participating Medical Group to another Participating IPA/Participating Medical Group by calling the Plan at 1-800-892-2803.

The change will be effective the first day of the month following your call. However, if you are an Inpatient or in the third trimester of pregnancy at the time of your request, the change will not be effective until you are no longer an Inpatient or until your pregnancy is completed.

When necessary, Participating IPAs/Participating Medical Groups have the right to request the removal of members from their enrollment. Their request cannot be based upon the type, amount or cost of services required by any member. If the Plan determines that the Participating IPA/Participating Medical Group has sufficient cause and approves such a request, such members will be offered enrollment in another Participating IPA or Participating Medical Group or enrollment in any other health care coverage then being provided by their Group, subject to the terms and conditions of such other coverage. The change will be effective no later than the first day of the month following 45 days from the date the request is received.

Selecting a Different Participating IPA/Participating Medical Group for Your Newborn

You may select a Participating IPA/Participating Medical Group for your newborn child. Your newborn will remain with the mother's Participating IPA/Participating Medical Group/Woman's Principal Health Care Provider, if one

has been selected, from the date of birth to the end of the month in which he/she is discharged from the Hospital. Your newborn may be added to the selected Participating IPA/Participating Medical Group on the first day of the month following discharge from the Hospital.

Transition of Care Benefits

If you are a new HMO enrollee and you are receiving care for a condition that requires an Ongoing Course of Treatment or if you have entered into the second or third trimester of pregnancy, and your Physician does not belong to the Plan's network, but is within the Plan's service area, you may request the option of transition of care benefits. You must submit a written request to the Plan for transition of care benefits within 15 business days of your eligibility effective date.

If you are a current HMO enrollee and you are receiving care for a condition that requires an Ongoing Course of Treatment or if you have entered into the second or third trimester of pregnancy and your Primary Care Physician or Woman's Principal Health Care Provider leaves the Plan's network, you may request the option of transition of care benefits. You must submit a written request to the Plan for transition of care benefits within 30 business days after receiving notification of your Primary Care Physician or Woman's Principal Health Care Provider's termination.

The Plan may authorize transition of care benefits for a period up to 90 days. Authorization of benefits is dependent on the Physician's agreement to contractual requirements and submission of a detailed treatment plan.

A written notice of the Plan's determination will be sent to you within 15 business days of receipt of your request.

PHYSICIAN BENEFITS

This section of your Certificate explains what your benefits are when you receive care from a Physician.

Remember, to receive benefits for Covered Services they must be performed by or ordered by your Primary Care Physician or Woman's Principal Health Care Provider. In addition, only services performed by Physicians are eligible for benefits unless another Provider, for example, a Dentist, is specifically mentioned in the description of the service.

Whenever we use "you" or "your" in describing your benefits, we mean all eligible family members who are covered under Family Coverage.

COVERED SERVICES

Your coverage includes benefits for the following Covered Services:

Surgery — when performed by a Physician, Dentist or Podiatrist.

However, benefits for oral Surgery are limited to the following services:

1. surgical removal of completely bony impacted teeth;
2. excision of tumors or cysts from the jaws, cheeks, lips, tongue, roof or floor of the mouth;
3. surgical procedures to correct accidental injuries of the jaws, cheeks, lips, tongue, roof or floor of the mouth;
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:

- **Anesthesia** — if administered in connection with a covered surgical procedure by a Physician, Dentist or Podiatrist other than the operating surgeon or by a Certified Registered Nurse Anesthetist.

In addition, benefits will be provided for anesthesia administered in connection with dental care treatment rendered in a Hospital or Ambulatory Surgical Facility if (a) a child is age 6 and under, (b) you have a chronic disability that is the result of a mental or physical impairment, is likely to continue and that substantially limits major life activities such as self-care, receptive and expressive language, learning, mobility, capacity for independent living or economic self-sufficiency or (c) you have a medical condition requiring hospitalization or general anesthesia for dental care.

- **An assistant surgeon** — that is, a Physician, Dentist or Podiatrist who actively assists the operating surgeon in the performance of a covered surgical procedure.

Medical Care

Benefits will be provided for Medical Care rendered to you:

- when you are an Inpatient in a Hospital or Skilled Nursing Facility;
- when you are a patient in a Partial Hospitalization Psychiatric Treatment Program or Home Health Care Program; or
- on an Outpatient basis in your Physician's office or your home.

Medical Care visits will only be covered for as long as your stay in a particular facility or program is eligible for benefits (as specified in the Hospital Benefits Section of this Certificate).

Psychiatric Care is also a benefit under your Medical Care coverage. In addition to a Physician, Psychiatric Care rendered under the supervision of a Physician by a psychiatric social worker or other mental health professional is covered.

Benefits for Inpatient Psychiatric Care are limited to the number of Hospital days available for the treatment of Mental Illness (as specified in the Hospital Benefits Section of this Certificate).

Benefits for Outpatient Psychiatric Care are limited to 30 visits per calendar year. For Outpatient group therapy, every two visits will be charged as one Outpatient Psychiatric Care visit.

Consultations — that is, examination and/or treatment by a Physician to obtain his/her advice in the diagnosis or treatment of a condition which requires special skill or knowledge.

Outpatient Periodic Health Examinations — including the taking of your medical history, physical examination and any diagnostic tests necessary because of your age, sex, medical history or physical condition. You are eligible for these examinations as often as your Primary Care Physician or Woman's Principal Health Care Provider, following generally accepted medical practice, finds necessary.

Covered Services include, but are not limited to:

- mammograms;
- routine cervical smears or Pap smears;
- routine prostate-specific antigen tests and digital rectal examinations;
- colorectal cancer screening — as prescribed by a Physician, in accordance with the published American Cancer Society guidelines on colorectal cancer screening or other existing colorectal cancer screening guidelines issued by nationally recognized professional medical societies or federal government agencies, including the National Cancer Institute, the Centers for Disease Control and Prevention, and the American College of Gastroenterology; and
- ovarian cancer screening — using CA-125 serum tumor marker testing, transvaginal ultrasound and pelvic examination.

Benefits will also be provided for pre-school, school or pre-marital examinations that are required by state or federal law. Benefits are not available for recreation-

al/camp physicals or sports physicals or for examinations done for insurance or employment screening purposes.

Routine Pediatric Care — that is, the routine health care of infants and children including examinations, tests, immunizations and diet regulation. Children are eligible for benefits for these services as often as is felt necessary by their Primary Care Physician.

Diagnostic Services — these services will be covered when rendered by a Dentist or Podiatrist, in addition to a Physician, but only when they are rendered in connection with covered Surgery.

Injected Medicines — that is, drugs that cannot be self-administered and which must be administered by injection. Benefits will be provided for the drugs and the administration of the injection. This includes routine immunizations and injections that you may need for traveling.

Electroconvulsive Therapy — including benefits for anesthesia administered with the electroconvulsive therapy if the anesthesia is administered by a Physician other than the one administering the therapy.

Radiation Therapy — that is, the use of ionizing radiation in the treatment of a medical illness or condition.

Chemotherapy — that is, the treatment of malignancies with drugs.

Outpatient Rehabilitative Therapy — including, but not limited to, Speech Therapy, Physical Therapy and Occupational Therapy, limited to therapy which is expected to result in significant improvement within two months in the condition for which it is rendered, as determined by your Primary Care Physician or Woman's Principal Health Care Provider, and to a combined maximum of 60 treatments per calendar year.

Outpatient Respiratory Therapy — when rendered for the treatment of an illness or injury by or under the supervision of a qualified respiratory therapist.

Chiropractic and Osteopathic Manipulation — benefits will be provided for manipulation or adjustment of osseous or articular structures, commonly referred to as chiropractic and osteopathic manipulation, when performed by a person licensed to perform such procedures.

Hearing Screening — when done to determine the need for hearing correction. Benefits will not be provided for hearing aids.

Diabetes Self-Management Training and Education — benefits will be provided for Outpatient self-management training, education and medical nutrition therapy. Benefits will be provided if these services are rendered by a Physician, or duly certified, registered or licensed health care professional with expertise in diabetes management. Benefits are also available for regular foot care examinations by a Physician or Podiatrist.

Routine Vision Examinations — benefits will be provided for a routine vision examination, limited to one visit per a 12 month period, without a referral from your Primary Care Physician or Woman's Principal Health Care Provider for vi-

sion examinations done to determine the need for vision correction including determination of the nature and degree of refractive errors of the eyes.

The examination must be rendered by an Optometrist or Physician who has an agreement with the Plan, directly or indirectly, to provide routine vision examinations to you. Routine vision examinations do not include medical or surgical treatment of eye diseases or injuries.

Benefits will not be provided for eyeglasses or contact lenses.

Dental Accident Care — that is, 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 is to sound natural teeth. A sound natural tooth is any tooth that has an intact root or is part of a permanent bridge.

Family Planning Services — including family planning counseling, prescribing of contraceptive drugs, fitting of contraceptive devices and sterilization. See Outpatient Contraceptive Services below for additional benefits.

Benefits are not available under this Benefit Section for the actual contraceptive drugs or for repeating or reversing sterilization.

Outpatient Contraceptive Services — benefits will be provided for prescription contraceptive devices, injections, implants and Outpatient contraceptive services. Outpatient contraceptive services means consultations, examinations, procedures and medical services provided on an Outpatient basis and related to the use of contraceptive methods (including natural family planning) to prevent an unintended pregnancy.

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

Investigational Cancer Treatment

Benefits will be provided for routine patient care in conjunction with investigational cancer treatments, when medically appropriate and you have a terminal condition related to cancer, that according to the diagnosis of your Physician is considered life threatening.

Infertility Treatment

Benefits will be provided for Covered Services rendered in connection with the diagnosis and/or treatment of infertility including, but not limited to, in vitro fertilization, uterine embryo lavage, embryo transfer, artificial insemination, gamete intrafallopian tube transfer, zygote intrafallopian tube transfer, low tubal ovum transfer and intracytoplasmic sperm injection.

Infertility means the inability to conceive a child after one year of unprotected sexual intercourse or the inability to sustain a successful pregnancy. The one year requirement will be waived if your Physician determines a medical condition exists that renders conception impossible through unprotected sexual intercourse, including but not limited to, congenital absence of the uterus or ovaries, absence of the uterus or ovaries due to surgical removal due to a medical condition, or involuntary sterilization due to chemotherapy or radiation treatments.

Unprotected sexual intercourse means sexual union between a male and a female, without the use of any process, device or method that prevents conception, including but not limited to, oral contraceptives, chemicals, physical or barrier contraceptives, natural abstinence or voluntary permanent surgical procedures.

Benefits for treatments that include oocyte retrievals will be provided only when;

- you have been unable to attain or sustain a successful pregnancy through reasonable, less costly medically appropriate infertility treatments; however, this requirement will be waived if you or your partner has a medical condition that renders such treatment useless); and
- you have not undergone four (4) completed oocyte retrievals, except that if a live birth followed a completed oocyte retrieval, two (2) more completed oocyte retrievals shall be covered.

Benefits will also be provided for medical expenses of an oocyte or sperm donor for procedures utilized to retrieve oocytes or sperm, and the subsequent procedure used to transfer the oocytes or sperm to you. Associated donor medical expenses are also covered, including but not limited to, physical examinations, laboratory screenings, psychological screenings and prescription drugs.

The maximum number of completed oocyte retrievals you are eligible for in your lifetime is six. This maximum applies regardless of the source of payment. Following the final completed oocyte retrieval, benefits will be provided for one subsequent procedure to transfer the oocytes or sperm to you. Thereafter, you will have no benefits for infertility treatment.

Benefits will not be provided for the following:

1. Reversal of voluntary sterilization. However, in the event a voluntary sterilization is successfully reversed, benefits will be provided if your diagnosis meets the definition of “infertility” as stated above.
2. Services or supplies rendered to a surrogate, except that costs for procedures to obtain eggs, sperm or embryos from you will be covered if you choose to use a surrogate.
3. Selected termination of an embryo in cases where the mother’s life is not in danger.
4. Cryo-preservation or storage of sperm, eggs or embryos, except for those procedures which use a cryo-preserved substance.
5. Non-medical costs of an egg or sperm donor.
6. Travel costs for travel within 100 miles of the covered person’s home or which is not medically necessary or which is not required by the Plan.
7. Infertility treatments which are determined to be Investigational, in writing, by the American Society for Reproductive Medicine or American College of Obstetrics and Gynecology.
8. Infertility treatment rendered to your dependents under the age of 18.

In addition to the above provisions, in vitro fertilization, gamete intrafallopian tube transfer, zygote intrafallopian tube transfer, low tubal ovum transfer and in-

tracytoplasmic sperm injection procedures must be performed at medical facilities that conform to the American College of Obstetrics and Gynecology guidelines for in vitro fertilization clinics or to the American Society for Reproductive Medicine minimal standards for programs of in vitro fertilization.

Mastectomy Related Services

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

Maternity Services

Your benefits for maternity services are the same as your benefits for any other condition and are available whether you have Individual Coverage or Family Coverage. Benefits will be provided for delivery charges and for any of the previously described Covered Services when rendered in connection with pregnancy. Benefits will not be provided for any treatment of an illness or injury to the newborn child unless you have Family Coverage. (Remember, you must add the newborn child within 31 days of the date of birth.)

Coverage will be provided for the mother and the newborn for a minimum of:

1. 48 hours of inpatient care following a vaginal delivery, or
2. 96 hours of inpatient care following a delivery by caesarean section,

except as may be indicated by the following: A shorter length of hospital inpatient stay related to maternity and newborn care may be provided if the attending physician determines, in accordance with the protocols and guidelines developed by the American College of Obstetrics and Gynecology or by the American Academy of Pediatrics, that the mother and the newborn meet the appropriate guidelines for a shorter length of stay based upon evaluation of the mother and newborn. Such an earlier discharge may only be provided if there is coverage and availability of a post-discharge physician office visit or an in-home nurse visit to verify the condition of the infant in the first 48 hours after discharge.

Your coverage also includes benefits for elective abortions, if legal where performed, limited to two abortions per person per lifetime.

Please note, as with all other services, benefits will only be provided for maternity services and/or care of the newborn child when such services have been authorized by your Participating IPA/Participating Medical Group or Woman's Principal Health Care Provider. If you choose to have your obstetrical or pediatric care rendered by a Physician whose services have not been authorized by your Participating IPA/Participating Medical Group or Woman's Principal Health Care

Provider, the Plan will neither provide benefits for such care nor coordinate benefits with any other health care coverage that you may have.

URGENT CARE

This benefit provides medically necessary outpatient care if you are outside the Plan's service area and experience an unexpected illness or injury that would not be considered an Emergency Condition, but which should be treated before returning home. Services usually are provided at a physician's office. If you require such Urgent Care, you should contact 1-800-810-BLUE. You will be given the names and addresses of nearby participating Physicians and Hospitals that you can contact to arrange an appointment for Urgent Care.

Payment for Urgent Care Treatment

100% of the Provider's Charge will be paid for Urgent Care received outside of the Plan's service area. You will be responsible for any Copayment(s), if applicable.

Should you be admitted to the Hospital as an Inpatient, benefits will be paid as explained in the Hospital Benefits and Physician Benefits Sections of this Certificate. Your Primary Care Physician or Woman's Principal Health Care Provider is responsible for coordinating all of your health care needs. Therefore, it is especially important for you or your family to contact your Primary Care Physician or Woman's Principal Health Care Provider as soon as possible if Inpatient Hospital care is required.

FOLLOW-UP CARE

If you will be traveling and know that you will require follow-up care for an existing condition, contact 1-800-810-BLUE. You will be given the names and addresses of nearby participating Physicians that you can contact to arrange the necessary follow-up care. (Examples of follow-up care include removal of stitches, removal of a cast, Physical Therapy, monitoring blood tests, and kidney dialysis.)

Payment for Follow-Up Care Treatment

100% of the Provider's Charge will be paid for follow-up care received outside of the Plan's service area. You will be responsible for any Copayment(s), if applicable.

COST TO YOU FOR PHYSICIAN SERVICES

The Covered Services of this benefit section are covered in full, with no cost to you, except as follows:

Benefits for Outpatient Psychiatric Care are subject to a Copayment of \$15 per visit and then will be paid in full.

Benefits for all other Covered Services rendered on an Outpatient basis, except for Surgery or Maternity Services, are subject to a Copayment of \$15 per visit, unless otherwise specified in this Certificate, and then will be paid in full when such services are received from a:

- Physician
- Physician Assistant
- Certified Nurse Midwife
- Certified Nurse Practitioner
- Certified Registered Nurse Anesthetist
- Certified Clinical Nurse Specialist

Benefits for Outpatient visits to a Specialist Physician's office are subject to a separate Copayment of \$25 per visit and then will be paid in full.

Benefits for Outpatient Rehabilitative Therapy are subject to a Copayment of \$15 per treatment and then will be paid in full. Such Copayment will be waived if the therapy is obtained in a Physician's office.

HOSPITAL BENEFITS

This section of your Certificate explains what your benefits are when you receive care in a Hospital or other health care facility. Benefits are only available for services rendered by a Hospital unless another Provider is specifically mentioned in the description of the service.

Remember, to receive benefits for Covered Services they must be ordered or approved by your Primary Care Physician or Woman's Principal Health Care Provider.

Whenever we use "you" or "your" in describing your benefits, we mean all eligible family members who are covered under Family Coverage.

COVERED SERVICES

Inpatient Care

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

1. **Bed, board and general nursing care** when you are in:
 - a semi-private room or a private room – must be ordered by your Primary Care Physician or Woman's Principal Health Care Provider.
 - an intensive care unit.
2. **Ancillary services** (such as operating rooms, drugs, surgical dressings and lab work).

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

Number of Inpatient Days

There are no limits on the number of days available to you for Inpatient care in a Hospital or other eligible facility except that Inpatient care for the treatment of Mental Illness is limited to 30 days per calendar year.

Every two days of Mental Illness treatment in a Partial Hospitalization Psychiatric Treatment Program or Participating IPA/Participating Medical Group-approved day Hospital, residential non-Hospital or intensive Outpatient treatment mode will be charged as one day against the days available for Inpatient treatment of Mental Illness.

Outpatient Care

You are entitled to benefits for the following services when you receive them from a Hospital, or other specified Provider, on an Outpatient basis:

1. **Surgery**— when performed in a Hospital or Ambulatory Surgical Facility.
2. **Diagnostic Services** — that is, tests performed to diagnose your condition because of your symptoms or to determine the progress of your illness or injury.

3. **Radiation Therapy** — that is, the use of ionizing radiation in the treatment of a medical illness or condition.
4. **Chemotherapy** — that is, the treatment of malignancies with drugs.
5. **Electroconvulsive Therapy**
6. **Renal Dialysis Treatments and Continuous Ambulatory Peritoneal Dialysis Treatment** — when received in a Hospital or a Dialysis Facility. Benefits for treatment in your home are available if you are homebound (that is, unable to leave home without assistance and requiring supportive devices or special transportation) and are rendered under the supervision of a Hospital or Dialysis Facility health care professional.

Special Programs

You are entitled to benefits for the special programs listed below. The services covered under these programs are the same as those that are available when you are an Inpatient in a Hospital. These programs are as follows:

1. **Coordinated Home Care Program**
2. **Pre-Admission Testing** — This is a program in which preoperative tests are given to you as an Outpatient in a Hospital to prepare you for Surgery that you are scheduled to have as an Inpatient.
3. **Partial Hospitalization Psychiatric Treatment** — This is a therapeutic treatment program in a Hospital for patients with Mental Illness. One day will be deducted from your available Inpatient Mental Illness treatment days for every two days of care in a Partial Hospitalization Psychiatric Treatment Program.

Surgical Implants

Your coverage includes benefits for surgically implanted internal and permanent devices. Examples of these devices are internal cardiac valves, internal pacemakers, mandibular reconstruction devices, bone screws and vitallium heads for joint reconstruction.

Maternity Services

Your benefits for services rendered in connection with pregnancy are the same as your benefits for any other condition and are available whether you have Individual Coverage or Family Coverage. In addition to all of the previously described Covered Services, routine Inpatient nursery charges for the newborn child are covered, even under Individual Coverage. (If the newborn child needs treatment for an illness or injury, that care will only be covered if you have Family Coverage. Remember, you must add the newborn child within 31 days of the date of birth.)

Coverage will be provided for the mother and the newborn for a minimum of:

1. 48 hours of inpatient care following a vaginal delivery, or
2. 96 hours of inpatient care following a delivery by caesarean section,

except as may be indicated by the following: A shorter length of hospital inpatient stay related to maternity and newborn care may be provided if the attending physician determines, in accordance with the protocols and guidelines developed by the American College of Obstetricians and Gynecologists or by the American Academy of Pediatrics, that the mother and the newborn meet the appropriate guidelines for a shorter length of stay based upon evaluation of the mother and newborn. Such an earlier discharge may only be required if there is coverage and availability of a post-discharge physician office visit or an in-home nurse visit to verify the condition of the infant in the first 48 hours after discharge.

Your coverage also includes benefits for elective abortions, if legal where performed, limited to two abortions per person per lifetime.

Please note, as with all other services, benefits will only be provided for maternity services and/or care of the newborn child when such services have been authorized by your Participating IPA/Participating Medical Group or Woman's Principal Health Care Provider. If you choose to have your obstetrical or pediatric care rendered by a Physician whose services have not been authorized by your Participating IPA/Participating Medical Group or Woman's Principal Health Care Provider, the Plan will neither provide benefits for such care nor coordinate benefits with any other health care coverage that you may have.

URGENT CARE

This benefit provides medically necessary outpatient care if you are outside the Plan's service area and experience an unexpected illness or injury that would not be considered an Emergency Condition, but which should be treated before returning home. Services usually are provided at a physician's office. If you require such Urgent Care, you should contact 1-800-810-BLUE. You will be given the names and addresses of nearby participating Physicians and Hospitals that you can contact to arrange an appointment for Urgent Care.

Payment for Urgent Care Treatment

100% of the Provider's Charge will be paid for Urgent Care received outside of the Plan's service area. You will be responsible for any Copayment(s), if applicable.

Should you be admitted to the Hospital as an Inpatient, benefits will be paid as explained in the Hospital Benefits and Physician Benefits Sections of this Certificate. Your Primary Care Physician or Woman's Principal Health Care Provider is responsible for coordinating all of your health care needs. Therefore, it is especially important for you or your family to contact your Primary Care Physician or Woman's Principal Health Care Provider as soon as possible if Inpatient Hospital care is required.

FOLLOW-UP CARE

If you will be traveling and know that you will require follow-up care for an existing condition, contact 1-800-810-BLUE. You will be given the names and addresses of nearby participating Physicians that you can contact to arrange the necessary follow-up care. (Examples of follow-up care include removal of

stitches, removal of a cast, Physical Therapy, monitoring blood tests, and kidney dialysis.)

Payment for Follow-Up Care Treatment

100% of the Provider's Charge will be paid for follow-up care received outside of the Plan's service area. You will be responsible for any Copayment(s), if applicable.

BENEFIT PAYMENT FOR HOSPITAL SERVICES

Each time you are admitted to a Hospital, Skilled Nursing Facility or Partial Hospitalization Psychiatric Treatment Program, you must satisfy a \$100 deductible. However, if your admission to a Skilled Nursing Facility or Partial Hospitalization Psychiatric Treatment Program immediately follows an Inpatient Hospital stay, then the deductible will not apply to such admission. After the deductible, benefits will be provided for 100% of the Provider's Charge.

Benefits for Outpatient Surgery are subject to a Copayment of \$50 per visit and then will be paid in full.

SUPPLEMENTAL BENEFITS

When you are being treated for an illness or injury, your treatment may require the use of certain special services or supplies in addition to those provided in the other benefit sections of this Certificate. Your coverage includes benefits for certain supplemental services and supplies and this section of your Certificate explains what those benefits are.

Remember, these services and supplies must be provided or ordered by your Primary Care Physician or Woman's Principal Health Care Provider.

COVERED SERVICES

Your coverage includes benefits for the following Covered Services:

- **Blood and Blood Components**
- **Medical and Surgical Dressings, Supplies, Casts and Splints**
- **Prosthetic Devices** — benefits will be provided for prosthetic devices, special appliances and surgical implants required for an illness or injury when:
 1. they are required to replace all or part of an organ or tissue of the human body; or
 2. they are required to replace all or part of the function of a non-functioning or malfunctioning organ or tissue.

Adjustments, repairs and replacements of these devices, appliances and implants are also covered when required because of wear or a change in your condition. Benefits will not be provided for dental appliances or hearing aids or for replacement of cataract lenses unless a prescription change is required.

- **Durable Medical Equipment** — that is, durable equipment which primarily serves a medical purpose, is appropriate for home use and generally is not useful in the absence of injury or disease. Benefits will be provided for the rental of a piece of equipment (not to exceed the total cost of equipment) or purchase of the equipment. Durable medical equipment must be rented or purchased from a Plan contracting durable medical equipment provider. Contact your Participating IPA/Participating Medical Group prior to purchasing or renting such equipment.

Examples of durable medical equipment are wheelchairs, hospital beds, glucose monitors and ventilators. Benefits will not be provided for strollers, electric scooters, back-up or duplicate equipment, ramps or other environmental devices, or clothing or special shoes.

PAYMENT FOR COVERED SERVICES

100% of the Provider's Charge will be paid for the Covered Services specified above.

EMERGENCY CARE BENEFITS

This section of your Certificate explains your emergency care benefits.

IN-AREA TREATMENT OF AN EMERGENCY

You are considered to be in your Participating IPA's/Participating Medical Group's treatment area if you are within 30 miles of your Participating IPA/Participating Medical Group.

Although you may go directly to the nearest Hospital emergency room to obtain treatment for an Emergency Condition, we recommend that you contact your Primary Care Physician or Woman's Principal Health Care Provider first if you are in your Participating IPA's/Participating Medical Group's treatment area. Benefits will be provided for the Hospital and Physician services that he/she authorizes.

If you obtain emergency treatment in the Hospital emergency room, your Primary Care Physician or Woman's Principal Health Care Provider must be notified of your condition as soon as possible and benefits will be limited to the initial treatment of your emergency unless further treatment is ordered by your Primary Care Physician or Woman's Principal Health Care Provider. If Inpatient Hospital care is required, it is especially important for you or your family to contact your Primary Care Physician or Woman's Principal Health Care Provider as soon as possible. All Participating IPAs/Participating Medical Groups have 24 hour phone service.

Payment for In-Area Emergency Treatment

Benefits for emergency treatment received in your Participating IPA's/Participating Medical Group's treatment area will be paid at 100% of the Provider's Charge.

However, each time you receive emergency treatment in a Hospital emergency room, you will be responsible for a Copayment of \$75. The emergency room Copayment does not apply to services provided for the treatment of sexual assault.

Should you be admitted to the Hospital as an Inpatient, benefits will be paid as explained in the Hospital Benefits and Physician Benefits Sections of this Certificate. If you are admitted to the Hospital as an Inpatient immediately following emergency treatment, the emergency room Copayment will be waived.

OUT-OF-AREA TREATMENT OF AN EMERGENCY

If you are more than 30 miles away from your Participating IPA/Participating Medical Group and need to obtain treatment for an Emergency Condition, benefits will be provided for the Hospital and Physician services that you receive. Benefits are available for the initial treatment of the emergency and for related follow-up care but only if it is not reasonable for you to obtain the follow-up care from your Primary Care Physician or Woman's Principal Health Care Provider. If you are not sure whether or not you are in your Participating IPA's/Participating Medical Group's treatment area, call them and they will tell you.

Payment for Out-of-Area Emergency Treatment

Benefits for emergency treatment received outside of your Participating IPA's/ Participating Medical Group's treatment area will be paid at 100% of the Provider's Charge.

However, each time you receive emergency treatment in a Hospital emergency room, you will be responsible for a Copayment of \$75. The emergency room Copayment does not apply to services provided for the treatment of sexual assault.

Should you be admitted to the Hospital as an Inpatient, benefits will be paid as explained in the Hospital Benefits and Physician Benefits Sections of this Certificate. If you are admitted to the Hospital as an Inpatient immediately following emergency treatment, the emergency room Copayment will be waived.

EMERGENCY AMBULANCE BENEFITS

Benefits for emergency ambulance transportation are available when:

1. such transportation is ordered by your Primary Care Physician or Woman's Principal Health Care Provider; or
2. the need for such transportation has been reasonably determined by a Physician, public safety official or other emergency medical personnel rendered in connection with an Emergency Condition.

Benefits are available for transportation between your home or the scene of an accident or medical emergency and a Hospital or Skilled Nursing Facility. If there are no facilities in the local area equipped to provide the care needed, benefits will be provided for transportation to the closest facility that can provide the necessary services. Only the use of a certified ground ambulance is covered.

100% of the Provider's Charge will be paid for emergency ambulance transportation.

CHEMICAL DEPENDENCY TREATMENT BENEFITS

Your coverage includes benefits for the treatment of Chemical Dependency.

Covered Services are the same as those provided for any other condition, as specified in the other benefit sections of this Certificate. In addition, benefits are available for Covered Services provided by a Chemical Dependency Treatment Facility in the HMO Illinois Chemical Dependency Network. To obtain benefits for Chemical Dependency Treatment, you must call the HMO Illinois Chemical Dependency Hotline at 1-800-346-3986.

Benefits are available through the HMO Illinois Chemical Dependency Network for the treatment of Chemical Dependency whether or not the Covered Services rendered have been ordered by your Primary Care Physician or Woman's Principal Health Care Provider.

Inpatient Benefits

Benefits will be provided for 30 days of Inpatient Chemical Dependency Treatment per calendar year.

Every two days of care in a Participating IPA/Participating Medical Group-approved day Hospital, residential non-Hospital or intensive Outpatient treatment mode will be charged as one day against the days available for Inpatient Chemical Dependency Treatment.

Each time you are admitted to a Hospital or Chemical Dependency Treatment Facility, you must satisfy a \$100 deductible. After the deductible, benefits will be paid at 100% of the Provider's Charge.

Outpatient Benefits

Benefits will be provided for 30 Outpatient Chemical Dependency Treatment visits per calendar year. For Outpatient group treatment, every two visits will be charged as one Outpatient Chemical Dependency Treatment visit.

Benefits for Outpatient Chemical Dependency Treatment are subject to a \$15 Co-payment per visit and then will be paid at 100% of the Provider's Charge.

Detoxification

Covered Services received for detoxification are not subject to the Chemical Dependency Treatment provisions specified above. Benefits for Covered Services received for detoxification will be provided under the Hospital Benefits and Physician Benefits Sections of this Certificate, as for any other condition.

AWAY FROM HOME CARE® BENEFITS

The Plan is a participant in a nation-wide network of Blue Cross and Blue Shield-affiliated plans. This enables the Plan to provide you with Guest Membership benefits when you are outside the service-area of the Plan.

GUEST MEMBERSHIP

If you will be living outside of the Home Plan's service area for more than 90 days, but will maintain a permanent residence within the Plan's service area, the Home Plan will establish a Guest Membership for you with a Host Plan serving the area in which you will be staying.

Under this arrangement, the Plan is referred to as the "**Home Plan**". The Blue Cross and Blue Shield plan in the area in which you are temporarily residing is called the "**Host Plan**".

This would apply for members who are:

1. On an extended work assignment in another state for a period of 90 days to six months;
2. Long-term travelers who will be out of the Home Plan's service area for 90 days to six months;
3. Eligible children at school out-of-state for periods of 90 days to one year; or
4. Eligible dependents living away from the employee's household in another state for periods of 90 days to one year.

Guest memberships for eligible children who are at school out-of state or for eligible dependents who live in another state may be renewed at the end of the period.

You will select a Primary Care Physician in your Guest Membership's area, just as you have within your home area. This Primary Care Physician will be responsible for coordinating all of your health care needs.

You may contact your Employer or Group Administrator to initiate the establishment of a Guest Membership, or you may call Member Services directly at 1-800-892-2803.

Benefits for Guest Membership

Each Host Plan establishes its own Guest Membership benefits. Consequently, your Guest Membership Copayment may differ from your Home Plan Copayments. However, all Basic Services will be covered. The Host Plan will provide you with an explanation of your benefits and Copayments.

HUMAN ORGAN TRANSPLANT BENEFITS

Your coverage includes benefits for human organ and tissue transplants when ordered by your Primary Care Physician or Woman's Principal Health Care Provider and when performed at a Plan approved center for human organ transplants. To be eligible for benefits, your Primary Care Physician or Woman's Principal Health Care Provider must contact the office of the Plan's Medical Director prior to scheduling the transplant Surgery.

All of the benefits specified in the other benefit sections of this Certificate are available for Surgery performed to transplant an organ or tissue. In addition, benefits will be provided for transportation of the donor organ to the location of the transplant Surgery, limited to transportation in the United States or Canada. Benefits will also be available for donor screening and identification costs, under approved matched unrelated donor programs. Payment for Covered Services received will be the same as that specified in those benefit sections.

Benefits will be provided for both the recipient of the organ or tissue and the donor subject to the following rules:

- If both the donor and recipient have coverage with the Plan, each will have his/her benefits paid by his or her own program.
- If you are the recipient and your donor does not have coverage from any other source, the benefits of this Certificate will be provided for both you and your donor. The benefits provided for your donor will be charged against your coverage under this Certificate.
- If you are the donor and coverage is not available to you from any other source, the benefits of this Certificate will be provided for you. However, benefits will not be provided for the recipient.

Whenever a heart, lung, heart/lung, liver, pancreas or pancreas/kidney transplant is recommended by your Primary Care Physician or Woman's Principal Health Care Provider, and you are the recipient of the transplant, benefits will be provided for transportation, lodging and meals for you and a companion. If the recipient of the transplant is a dependent child under the limiting age of this Certificate, benefits for transportation, lodging and meals will be provided for the transplant recipient and two companions. For benefits to be available, your place of residency must be more than 50 miles from the Hospital where the transplant will be performed.

- You and your companion are each entitled to benefits for lodging and meals up to a combined maximum of \$200 per day.
- Benefits for transportation, lodging and meals are limited to a maximum of \$10,000 per transplant.

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

1. Organ transplants, and/or services or supplies rendered in connection with an organ transplant, which are Investigational as determined by the appropriate technological body.

2. Drugs which are Investigational
3. Storage fees
4. Services provided to any individual who is not the recipient or actual donor, unless otherwise specified in this provision.
5. Cardiac rehabilitation services when not provided to the transplant recipient immediately following discharge from a Hospital for transplant Surgery.
6. Travel time or related expenses incurred by a Provider.

HOSPICE CARE BENEFITS

Your coverage includes benefits for services received in a Hospice Care Program. For benefits to be available for these services, they must have been ordered by your Primary Care Physician or Woman's Principal Health Care Provider.

In addition, they must be rendered by a Hospice Care Program Provider. However, for benefits to be available you must have a terminal illness with a life expectancy of one year or less as certified by your Primary Care Physician or Woman's Principal Health Care Provider; and you will no longer benefit from standard medical care, or have chosen to receive hospice care rather than standard care. Also, a family member or friend should be available to provide custodial type care between visits from Hospice Care Program Providers if hospice is being provided in the home.

The following services are covered under the Hospice Care Program:

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

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

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

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

Benefits are subject to the same payment provisions and day limitations specified in the Hospital Benefits and Physician Benefits Sections of this Certificate, depending upon the particular Provider involved (Hospital, Skilled Nursing Facility, Coordinated Home Care Program or Physician).

OUTPATIENT PRESCRIPTION DRUG PROGRAM BENEFITS

When you are being treated for an illness or accident, your Physician may prescribe certain drugs or medicines as part of your treatment. Your coverage includes benefits for drugs and supplies which are self-administered. This section of your Certificate explains which drugs and supplies are covered and the benefits that are available for them. Benefits will be provided only if such drugs and supplies are Medically Necessary.

PRIOR AUTHORIZATION REQUIREMENT

When certain medications and drug classes are prescribed, your Physician will be required to obtain authorization from the Plan in order to receive benefits.

Your Physician must send a letter to the Plan's prescription drug administrator explaining the reason for the prescription. The prescription drug administrator will review the letter and determine whether the reason for the prescription meets the criteria for medically necessary care. You and your Physician will be notified of the prescription drug administrator's determination within twenty-four (24) hours. No benefits will be provided for such drugs if prior authorization is not received.

You should refer to the formulary list, contact your Pharmacy or refer to the Blue Cross and Blue Shield website to determine which medications and drug classes require prior authorization.

COVERED SERVICES

The drugs and supplies for which benefits are available under this Benefit Section are:

- drugs which are self-administered that require, by federal law, a written prescription;
- injectable insulin and insulin syringes;
- diabetic supplies, as follows: test strips, glucagon emergency kits and lancets.

Benefits for self-injectable drugs are limited to:

- insulin;
- drugs prescribed for the treatment of Infertility, or
- drugs prescribed for a particular condition for which they have been specifically approved by the Food and Drug Administration.

Benefits for these drugs will be provided when:

- you have been given a written prescription for them by your Physician, Dentist, Optometrist or Podiatrist;

- you purchase the drugs from a Pharmacy or from a Physician, Dentist, Optometrist or Podiatrist who regularly dispenses drugs, and
- the drugs are self-administered.

Benefits will not be provided for:

- drugs used for cosmetic purposes;
- any devices or appliances except as specifically mentioned above;
- any charges that you may incur for the drugs being administered to you;
- drugs for which there is an over-the-counter product available with the same active ingredient(s);
- drugs which are not self-administered;

In addition, benefits will not be provided for any prescription or refill dispensed after one year from the date of the prescription.

One prescription means up to a 34 consecutive day supply for most medications. Certain drugs may be limited to less than a 34 consecutive day supply. However, for certain maintenance type drugs, larger quantities may be obtained through the 90-day supply prescription drug program. Specific information on these maintenance drugs can be obtained from a Prescription Drug Provider participating in the 90-day supply prescription drug program or the Plan. Benefits for prescription inhalants will not be restricted on the number of days before an inhaler refill may be obtained.

34-DAY SUPPLY PRESCRIPTION DRUG PROGRAM

Benefit payment for the 34-day supply prescription drug program

The benefits you receive for drugs will differ depending upon whether you purchase a generic Drug, Formulary brand-name Drug or a non-Formulary brand-name Drug, whether or not the drug is purchased from a Participating Prescription Drug Provider, and whether or not the drug is self-injectable.

When you purchase drugs from a Participating Prescription Drug Provider, you will not be charged any amount other than the specified Copayment amount. The Copayment amount differs for generic Drugs, Formulary brand-name Drugs, non-Formulary brand-name Drugs, and Self-Injectable Drugs. The Copayment amounts are shown in the Benefit Highlights section of this Certificate. You will be charged the Copayment amount for each prescription. There is no charge to you for diabetic supplies.

No benefits will be provided for drugs purchased from a Non-Participating Prescription Drug Provider in Illinois. However, if the Non-Participating Prescription Drug Provider is located outside of Illinois, then benefits for drugs purchased for emergency conditions will be provided at 100% of the amount that would have been paid had you purchased such drugs from a Participating Prescription Drug Provider, minus the Copayment amount.

90-DAY SUPPLY PRESCRIPTION DRUG PROGRAM

Benefit payment for the 90-day supply prescription drug program

In addition to the benefits described in this Benefit Section, your coverage includes benefits for maintenance type drugs obtained from a Prescription Drug Provider (which may include retail or mail order pharmacies) participating in the 90-day supply prescription drug program. You will not be charged any amount other than the specified Copayment amount. The Copayment amounts are shown in the Benefit Highlights section of this Certificate. There is no charge to you for diabetic supplies.

Benefits will not be provided for 90-day supply drugs purchased from a Prescription Drug Provider not participating in the 90-day supply program.

You can obtain an order form for the 90-day supply prescription drug program from your Group or from the Plan.

PRE-ADMISSION CERTIFICATION AND CONCURRENT REVIEW

Pre-Admission Certification and Concurrent Review are two programs that have been established to ensure that you receive the most appropriate and cost effective health care.

PRE-ADMISSION CERTIFICATION

Pre-Admission Certification applies when you need to be admitted to a Hospital as an Inpatient in other than an emergency situation. Prior to your admission, your Primary Care Physician or Woman's Principal Health Care Provider must obtain approval of your admission from the Participating IPA/Participating Medical Group with which he/she is affiliated or employed. The Participating IPA/Participating Medical Group may recommend other courses of treatment that could help you avoid an Inpatient stay. It is your responsibility to cooperate with any recommendations made by the Participating IPA/Participating Medical Group.

CONCURRENT REVIEW

Once you have been admitted to a Hospital as an Inpatient, your length of stay will be reviewed by the Participating IPA/Participating Medical Group. The purpose of that review is to ensure that your length of stay is appropriate given your diagnosis and the treatment that you are receiving. This is known as Concurrent Review.

If your Hospital stay is longer than the usual length of stay for your type of condition, the Participating IPA/Participating Medical Group will contact your Primary Care Physician or Woman's Principal Health Care Provider to determine whether there is a medically necessary reason for you to remain in the Hospital. Should it be determined that your continued stay in the Hospital is not medically necessary, you will be informed of that decision, in writing, and of the date that your benefits for that stay will end.

EXCLUSIONS — WHAT IS NOT COVERED

Expenses for the following are not covered under your benefit program:

- Services or supplies that are not specifically stated in this Certificate.
- Services or supplies that were not ordered by your Primary Care Physician or Woman’s Principal Health Care Provider except as explained in the Emergency Care Benefits and Chemical Dependency Treatment Benefits and, for routine vision examinations, Physician Benefits Sections of this Certificate.
- Services or supplies that were received prior to the date your coverage began or after the date that your coverage was terminated.
- Services or supplies for which benefits have been paid under any Workers’ Compensation Law or other similar laws whether or not you make a claim for such compensation or receive such benefits. However, this exclusion shall not apply if you are a corporate officer of any business or enterprise, defined as a “small business” under paragraph (b), Section 3 or the Illinois Small Business Purchasing Act, as amended, and are employed by the corporation and elect to withdraw yourself from the operation of the Illinois Workers’ Compensation Act according to the provisions of the Act.
- Services or supplies that are furnished to you by the local, state or federal government and services or supplies to the extent payments or benefits for such services or supplies are provided by or available from the local, state or federal government (for example, Medicare) whether or not those payments or benefits are received, except, however, this exclusion shall not be applicable to medical assistance benefits under Article V, VI, or VII of the Illinois Public Aid Code (Ill. Rev. Stat. ch. 23 §1-1 et seq.) or similar Legislation of any state, benefits provided in compliance with the Tax Equity and Fiscal Responsibility Act or as otherwise provided by law.
- Services or supplies rendered to you as the result of an injury caused by another person to the extent that you have collected damages for such injury and that the Plan has provided benefits for the services or supplies rendered in connection with such injury.
- Services or supplies that do not meet accepted standards of medical or dental practice including, but not limited to, services which are Investigational in nature.
- Custodial Care Service.
- Long Term Care Services.
- Respite Care Services, except as specifically mentioned under Hospice Care Benefits.
- Services or supplies rendered because of behavioral, social maladjustment, lack of discipline or other antisocial actions which are not specifically the result of Mental Illness.
- Special education therapy such as music therapy or recreational therapy.

- Cosmetic Surgery and related services and supplies, except for the correction of congenital deformities or for conditions resulting from accidental injuries, tumors or disease.
- 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 or charges for the transfer of medical records.
- 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 or, battery implants except as specifically stated in this Certificate.
- Prosthetic devices, special appliances or surgical implants which are for cosmetic purposes, the comfort or convenience of the patient or unrelated to the treatment of a disease or injury.
- Nutritional items such as infant formula, weight-loss supplements, over-the-counter food substitutes, non-prescription vitamins and herbal supplements.
- Blood derivatives which are not classified as drugs in the official formularies.
- Marriage counseling.
- Hypnotism.
- Inpatient and Outpatient Private Duty Nursing Service.
- Routine foot care, except for persons diagnosed with diabetes.
- Maintenance Occupational Therapy, Maintenance Physical Therapy and Maintenance Speech Therapy.
- Maintenance Care.
- Self-management training, education and medical nutrition therapy, except as specifically stated in this Certificate.
- Services or supplies which are rendered for the care, treatment, filling, removal, replacement or artificial restoration of the teeth or structures directly supporting the teeth except as specifically stated in this Certificate.
- Treatment of temporomandibular joint syndrome with intraoral prosthetic devices or any other method which alters vertical dimension or treatment of temporomandibular joint dysfunction not caused by documented organic joint disease or physical trauma.

- Services or supplies rendered for human organ or tissue transplants except as specifically provided for in this Certificate.
- Wigs (also referred to as cranial prostheses).

COORDINATION OF BENEFITS

Coordination of Benefits (COB) applies to this Benefit Program when you or your covered dependent has health care coverage under more than one Benefit Program. COB does not apply to the Outpatient Prescription Drug Program Benefits.

The order of benefit determination rules should be looked at first. Those rules determine whether the benefits of this Benefit Program are determined before or after those of another Benefit Program. The benefits of this Benefit Program:

1. Shall not be reduced when, under the order of benefit determination rules, this Benefit Program determines its benefits before another Benefit Program; but
2. May be reduced when, under the order of benefits determination rules, another Benefit Program determines its benefits first. This reduction is described below in “When this Benefit Program is a Secondary Program.”

In addition to the Definitions Section of this Certificate, the following definitions apply to this section:

ALLOWABLE EXPENSE.....means a Covered Service, when the Covered Service is covered at least in part by one or more Benefit Program covering the person for whom the claim is made.

The difference between the cost of a private Hospital room and the cost of a semi-private Hospital room is not considered an Allowable Expense under the above definition unless your stay in a private Hospital room is Medically Necessary either in terms of generally accepted medical practice, or as specifically defined in the Benefit Program.

When a Benefit Program provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both an Allowable Expense and a benefit paid.

BENEFIT PROGRAM.....means any of these which provides benefits or services for, or because of, medical or dental care or treatment:

- (i) Group insurance or group-type coverage, whether insured or uninsured. This includes prepayment, group practice or individual practice coverage.
- (ii) Coverage under a governmental plan, or coverage required or provided by law. This does not include a state plan under Medicaid (Title XIX of the Social Security Act).

Each contract or other arrangement under (i) or (ii) above is a separate benefit program. Also, if an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate program.

CLAIM DETERMINATION PERIOD.....means a calendar year. However, it does not include any part of a year during which a person has no coverage under this Benefit Program, or any part of a year before the date this COB provision or a similar provision takes effect.

PRIMARY PROGRAM or SECONDARY PROGRAM.....means the order of payment responsibility as determined by the order of benefit determination rules.

When this Benefit Program is the Primary Program, its benefits are determined before those of the other Benefit Program and without considering the other program's benefits.

When this Benefit Program is a Secondary Program, its benefits are determined after those of the other Benefit Program and may be reduced because of the other program's benefits.

When there are more than two Benefit Programs covering the person, this Benefit Program may be a Primary Program as to one or more other programs, and may be a Secondary Program as to a different program or programs.

ORDER OF BENEFIT DETERMINATION

When there is a basis for a Claim under this Benefit Program and another Benefit Program, this Benefit Program is a Secondary Program which has its benefits determined after those of the other program, unless:

1. The other Benefit Program has rules coordinating its benefits with those of this Benefit Program; and
2. Both those rules and this Benefit Program's rules, described below, require that this Benefit Program's benefits be determined before those of the other Benefit Program.

This Benefit Program determines its order of benefit payments using the first of the following rules which applies:

1. Non-Dependent or Dependent

The benefits of the Benefit Program which covers the person as an employee, member or subscriber (that is, other than a dependent) are determined before those of the Benefit Program which covers the person as dependent; except that, if the person is also a Medicare beneficiary, Medicare is:

- a. Secondary to the Benefit Program covering the person as a dependent; and
 - b. Primary to the Benefit Program covering the person as other than a dependent, for example a retired employee.
2. Dependent Child if Parents not Separated or Divorced

Except as stated in rule 3 below, when this Benefit Program and another Benefit Program cover the same child as a dependent of different persons, called "parents:"

- a. The benefits of the program of the parent whose birthday (month and day) falls earlier in a calendar year are determined before those of the program of the parent whose birthday falls later in that year; but

- b. If both parents have the same birthday, the benefits of the program which covered the parents longer are determined before those of the program which covered the other parent for a shorter period of time.

However, if the other Benefit Program does not have this birthday-type rule, but instead has a rule based upon gender of the parent, and if, as a result, the Benefit Programs do not agree on the order of benefits, the rule in the other Benefit Program will determine the order of benefits.

3. Dependent Child if Parents Separated or Divorced

If two or more Benefit Programs cover a person as a dependent child of divorced or separate parents, benefits for the child are determined in this order:

- a. First, the program of the parent with custody of the child;
- b. Then, the program of the spouse of the parent with the custody of the child; and
- c. Finally, the program of the parent not having custody of the child.

However, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the program of that parent has actual knowledge of those terms, the benefits of that program are determined first. The program of the other parent shall be the Secondary Program. This paragraph does not apply with respect to any Claim Determination Period or Benefit Program year during which any benefits are actually paid or provided before the entity has that actual knowledge. It is the obligation of the person claiming benefits to notify the Plan and, upon its request, to provide a copy of the court decree.

4. Dependent Child if Parents Share Joint Custody

If the specific terms of a court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the Benefit Programs covering the child shall follow the order of benefit determination rules outlined in 2 above.

5. Active or Inactive Employee

The benefits of a Benefit Program which covers a person as an employee who is neither laid off nor retired (or as that employee's dependent) are determined before those of a Benefit Program which covered that person as a laid off or retired employee (or as that employee's dependent). If the other Benefit Program does not have this rule, and if, as a result, the Benefit Programs do not agree on the order of benefits, this rule is ignored.

6. Continuation Coverage

If a person whose coverage is provided under a right of continuation pursuant to federal or state law also is covered under another Benefit Program, the following shall be the order of benefit determination:

- a. First, the benefits of a Benefit Program covering the person as an employee, member or subscriber (or as that person's dependent);
- b. Second, the benefits under the continuation coverage.

If the other Benefit Program does not contain the order of benefits determination described within this rule, and if, as a result, the programs do not agree on the order of benefits, this requirement shall be ignored.

7. Length of Coverage

If none of the above rules determines the order of benefits, the benefits of the Benefit Program which covered an employee, member or subscriber longer are determined before those of the Benefit Program which covered that person for the shorter term.

WHEN THIS BENEFIT PROGRAM IS A SECONDARY PROGRAM

In the event this Benefit Program is a Secondary Program as to one or more other Benefit Programs, the benefits of this Benefit Program may be reduced.

The benefits of this Benefit Program will be reduced when the sum of:

1. The benefits that would be payable for the Allowable Expenses under this Benefit Program in the absence of this COB provision; and
2. The benefits that would be payable for the Allowable Expenses under the other Benefit Programs, in the absence of provisions with a purpose like that of this COB provision, whether or not a claim is made;

Exceeds those Allowable Expenses in a Claim Determination Period. In that case, the benefits of this Benefit Program will be reduced so that they and the benefits payable under the other Benefit Programs do not total more than those Allowable Expenses.

If you are eligible for Medicare Part B, the benefits of this Benefit Program may be reduced taking into consideration the amount that would be payable for an Allowable Expense under Medicare Part B whether or not you have enrolled in Part B and/or received payment from Medicare.

When the benefits of this Benefit Program are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of this Benefit Program.

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts are needed to apply these COB rules. The Plan has the right to decide which facts it needs. It may get needed facts from or give them to any other organization or person. The Plan need not tell, or get the consent of, any person to do this. Each person claiming benefits under this Benefit Program must give the Plan any facts it needs to pay the Claim.

FACILITY OF PAYMENT

A payment made under another Benefit Program may include an amount which should have been paid under this Benefit Program. If it does, the Plan may pay

that amount to the organization which made that payment. That amount will then be treated as though it were a benefit paid under this Benefit Program. The Plan will not have to pay that amount again. The term “payment made” includes providing benefits in the form of services, in which case “payment made” means reasonable cash value of the benefits provided in the form of services.

RIGHT OF RECOVERY

If the amount of payments made by the Plan is more than it should have paid under this COB provision, it may recover the excess from one or more of:

1. The persons it has paid or for whom it has paid;
2. Insurance companies; or
3. Other organizations.

The “amount of payments made” includes the reasonable cash value of any benefits provided in the form of services.

REDUCTION IN BENEFITS

The amount by which your benefits under this Benefit Program have been reduced is called your “savings.” Savings can be used to pay for services that are not covered under this Benefit Program provided that the services are covered under another Benefit Program and were not completely paid for under that Benefit Program. Savings can only be used to pay for services rendered in the same calendar year in which the Claim that earned the savings is actually processed.

In order to have Claims paid from your savings, a Claim for such payment, including a statement of savings earned, must be submitted to the Plan no later than March 31st of the calendar year immediately following the calendar year in which the savings were earned.

HOW TO FILE A CLAIM

When you receive care from your Primary Care Physician or from another Provider who is affiliated with your Participating IPA/Participating Medical Group, or from your Woman's Principal Health Care Provider, a Claim for benefits does not have to be filed with the Plan. All you have to do is show your Plan ID card to your Provider. However, to receive benefits for care from another Physician or Provider, you must be referred to that Provider by your Primary Care Physician or Woman's Principal Health Care Provider.

When you receive care from Providers outside of your Participating IPA/Participating Medical Group (i.e. emergency care, medical supplies), usually all you have to do to receive your benefits under this Certificate is to, again, show your Plan ID card to the Provider. Any Claim filing required will be done by the Provider.

There may be situations when you have to file a Claim yourself (for example, if a Provider will not file one for you). To do so, send the following to the Plan:

1. an itemized bill from the Hospital, Physician or other Provider (including the Provider's name and address, the patient's name, the diagnosis, the date of service, a description of the service and the Claim Charge);
2. the Eligible Person's name and Plan ID number;
3. the patient's name, age and sex;
4. any additional relevant information.

Mail all of that information to:

**Blue Cross and Blue Shield
300 East Randolph Street
Chicago, Illinois 60601-5099**

In any case, it is your responsibility to make sure that the necessary Claim information has been provided to the Plan. Claims must be filed no later than December 31st of the calendar year following the year in which the Covered Service was rendered. For the purposes of this filing time limit, Covered Services rendered in December will be considered to have been rendered in the next calendar year.

If you have any questions about a Claim, call **Member Services at 1-800-892-2803**.

FILING OUTPATIENT PRESCRIPTION DRUG PROGRAM CLAIMS

In certain situations, you will have to file your own Claims in order to obtain benefits under the Outpatient Prescription Drug Program. This is primarily true when you did not receive an identification card, the pharmacy was unable to transmit a claim or you received benefits from a non-Participating Prescription Drug Provider. To do so, follow these instructions:

1. Complete an Outpatient Prescription Drug Program Claim Form. These forms are available from your Employee Benefits Department or from the Plan.
2. Attach copies of all pharmacy receipts to be considered for benefits. These receipts must be itemized.
3. Mail the completed Claim Form with attachments to:

Blue Cross and Blue Shield of Illinois
P. O. Box 64812
St. Paul, MN 55164-0812

In any case, Claims must be filed no later than one year after the date a service is received. Claims not filed within one year from the date a service is received, will not be eligible for payment.

CLAIM PROCEDURES

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

If the Claim is denied in whole or in part, you will receive a notice from the Plan with: (1) the reasons for denial; (2) a reference to the health care plan provisions on which the denial is based; (3) a description of additional information which may be necessary to perfect the appeal, and (4) an explanation of how you may have the Claim reviewed by the Plan if you do not agree with the denial.

CLAIM REVIEW PROCEDURES

If your Claim has been denied in whole or in part, you may have your Claim reviewed. The Plan will review its decision in accordance with the following procedure.

Within 180 days after you receive notice of a denial or partial denial, write or telephone the Plan. You will need to submit the reason why you do not agree with the denial or partial denial, comments and any additional medical information. Send your request to or contact:

Claim Review Section
Blue Cross and Blue Shield of Illinois
P. O. Box 805107
Chicago, Illinois 60680-4112
1-800-892-2803

You may also designate a representative to act for you during the review process. Your designation of a representative must be in writing as it is necessary to protect against disclosure of information about you except to your authorized representative.

The Plan will give you a written decision within 60 days after it receives your request for review. Upon completion of the review, you and your authorized representative may ask to see relevant documents used during the review process.

If you have any questions about the Claims procedures or the review process, write or call the Plan between the hours of 8:45 A.M. to 4:45 P.M., Monday through Friday.

Blue Cross and Blue Shield of Illinois
P. O. Box 805107
Chicago, IL 60680-4112
1-800-892-2803

INQUIRIES AND COMPLAINTS

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

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

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

- Claims
- Referrals to a Specialist
- Changing your Participating IPA or Participating Medical Group
- Quality of Care

You may contact **Member Services at 1-800-892-2803**, or you may write to:

Blue Cross and Blue Shield of Illinois
P. O. Box 805107
Chicago, Illinois 60680-4112

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

APPEALS

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

An appeal is an oral or written request for a review of an adverse decision or action by the Plan, its employees, or the Participating Medical Group/IPA. An appeal may be filed by you, a person designated to act on your behalf, your Pri-

mary Care Physician or Woman's Principal Health Care Provider or any health care provider.

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

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

URGENT/EXPEDITED CLINICAL APPEALS

Upon receipt of an Urgent/Expedited pre-service or concurrent Clinical Appeal, the Plan will notify the party filing the appeal, MG/IPA or Primary Care Physician (PCP) as soon as possible, but no more than 24 hours after submission of the appeal, of all the information needed to review the appeal. Additional information must be submitted within 24 hours of request. The Plan shall render a determination on the appeal within 24 hours after it receives the requested information.

CLINICAL APPEALS

Upon receipt of a non-urgent pre-service or post-service Clinical Appeal, the Plan will notify the party filing the appeal within three business days if additional information is needed to review the appeal. Additional information must be submitted within five calendar days of request. The Plan shall render a determination on the appeal within 15 business days after it receives the requested information.

NOTIFICATION

The Plan will notify the party filing the appeal, you, your Primary Care Physician or Woman's Principal Health Care Provider, and any health care provider who recommended the services involved in the appeal orally of its determination followed-up by a written notice of the determination.

The written notification will include:

- A clear and detailed reason for the determination.
- Medical or clinical criteria used in the determination.
- Procedures for requesting an external independent review, if your appeal is denied. An external independent reviewer shall be a clinical peer, have no direct financial interest in connection with the review and will not know your identity.

EXPEDITED EXTERNAL INDEPENDENT REVIEW

An expedited external independent review can be requested when a delay would significantly increase the risk to your health or when extended health care services, ordered by a health care provider for an Ongoing Course of Treatment, are at issue.

The external independent reviewer shall make a determination and provide notice of the determination within 24 hours of receiving all necessary information needed to review the case.

EXTERNAL INDEPENDENT REVIEW

You must submit a written request for a review within 30 days of receiving a denial of a Clinical Appeal. Any information or documentation to support your request for the health care services must be included.

Within 30 days of receipt of your request, the Plan will:

- select an external independent reviewer that is acceptable to you, your Primary Care Physician or Woman's Principal Health Care Provider, or other health care provider; and
- forward to the external independent reviewer all medical records and supporting documentation, a description of the issues including a statement of the Plan's decision, the criteria used and the medical and clinical reasons for the decision.

Within 5 days after receipt of the necessary information, the external independent reviewer will render a decision based on whether or not the health care services being appealed were medically appropriate and you will receive notification from the Plan. The decision of the external independent reviewer is final. If you disagree with the determination of the external independent reviewer, you may contact the Illinois Division of Insurance.

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

NON-CLINICAL APPEALS

Upon receipt of a pre-service or post-service Non-Clinical Appeal, the Plan will notify the party filing the appeal within three business days if additional information is needed to review the appeal. Additional information must be submitted within five calendar days of request. The Plan shall render a decision on the appeal within 15 business days after it receives the requested information.

NOTIFICATION

The Plan will notify you and the party filing the Non-Clinical Appeal orally of its determination, followed-up by a written notice of determination.

The written notification will include:

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

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

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

or

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

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

OTHER THINGS YOU SHOULD KNOW

REIMBURSEMENT PROVISION

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

- a. the Plan has the right to reimbursement for all benefits the Plan provided from any and all damages collected from the third party for those same expenses, whether by action at law, settlement, or compromise, by you or your legal representative as a result of that sickness or injury:
 - (i) in the case of health care facilities and certain contracted Providers, the calculation of any lien shall be based on the amount the Plan charges the group's experience for Covered Services rendered to you; and
 - (ii) in the case of Providers other than health care facilities, the calculation of any lien shall be based on the Plan's benefit payment for Covered Services rendered to you.
- b. the Plan is assigned the right to recover from the third party, or his or her insurer, to the extent of the benefits the Plan provided for that sickness or injury. The Plan shall have the right to first reimbursement out of all funds you, your covered dependents or your legal representative, are or were able to obtain for the same expenses the Plan has provided as a result of that sickness or injury.

For the purposes of this provision, the cost of benefits provided will be the charges that would have been billed if you had not been enrolled under this benefit program.

You are required to furnish any information or assistance and to provide any documents that the Plan may request in order to obtain its rights under this provision.

PLAN'S SEPARATE FINANCIAL ARRANGEMENTS WITH PROVIDERS

The Plan has contracts with certain Providers and other suppliers of goods and services for the provision of and/or payment for health care goods and services to all persons entitled to health care benefits under individual and group policies or contracts to which the Plan is a party, including all persons covered under your Group's Policy.

Under certain circumstances described in its contracts with such Providers and suppliers, the Plan may:

- receive substantial payments from Providers or suppliers with respect to goods, supplies and services furnished to all such persons for which the Plan was obligated to pay the Provider or supplier, or
- pay Providers or suppliers substantially less than their Claim Charges for goods or services, by discount or otherwise, or

- receive from Providers or suppliers other substantial allowances under the Plan’s contracts with them.

Your Group understands that the Plan may receive such payments, discounts, and/or other allowances during the term of the Policy.

Neither you nor your Group are entitled to receive any portion of any such payments, discounts, and/or other allowances. Any Copayments and/or deductibles payable by you are pre-determined fixed amounts, based upon the selected benefit plan, which are not impacted by any discounts or contractual allowances which the Plan may receive from a Provider.

OTHER BLUE CROSS AND BLUE SHIELD PLANS’ SEPARATE FINANCIAL ARRANGEMENTS WITH PROVIDERS

BlueCard

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

Under BlueCard, when you receive health care services outside of Illinois and from a Provider which does not have a contract with the Plan, the amount you pay, if not covered by a flat dollar Copayment, for Covered Services is calculated on the lower of:

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

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

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

PLAN'S SEPARATE FINANCIAL ARRANGEMENTS WITH PRESCRIPTION DRUG PROVIDERS

The Plan hereby informs you that it has contracts, either directly or indirectly, with Prescription Drug Providers (“Participating Prescription Drug Providers”) to provide prescription drug services to all persons entitled to prescription drug benefits under health policies and contracts to which the Plan is a party, including all persons covered under this Certificate. Under its contracts with Participating Prescription Drug Providers, the Plan may receive from these Providers discounts for prescription drugs dispensed to you. Neither the Group nor you are entitled to receive any portion of any such payments, discounts and/or other allowances.

In addition, the Plan has entered into agreements with certain entity(ies) to provide, on the Plan’s behalf, Claim payments and certain administrative services for your prescription drug benefits. This entity(ies) is referred to as a pharmacy benefit manager. The pharmacy benefit manager has agreements with pharmaceutical manufacturers to receive rebates for using their products. The pharmacy benefit manager shares a portion of those rebates with the Plan. Neither the Group nor you are entitled to receive any portion of such rebates as they are figured into the pricing of the product.

PAYMENT OF CLAIMS AND ASSIGNMENT OF BENEFITS

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

You will not receive any notices regarding Covered Services received from your Primary Care Physician (or other Providers who are part of your Participating IPA/Participating Medical Group) because Claims do not have to be filed for those services.

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

Neither this Certificate nor a covered person’s Claim for payment of benefits under this Certificate is assignable in whole or in part to any person or entity at any time. Coverage under this Certificate 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.

COVERED SERVICES EXPENSE LIMITATION

If, during any contract year, you have paid Copayments and/or deductibles for Covered Services under this Certificate the total amount of which equals \$1,500 per enrollee or \$3,000 per family, your benefits for any additional Covered Services that you may receive during that contract year, including any Copayment or deductible amounts, will be reimbursed by the Plan.

In the event your physician or the hospital requires you to pay any additional Copayments or deductible amounts after you have met the above provision, upon receipt of properly authenticated documentation, the Plan will reimburse to you, the amount of those Copayments and/or deductibles.

Copayments and deductibles required under this Certificate are not to exceed 50% of the Usual and Customary Fee for any single service.

The above Covered Services expense provisions are not applicable to the benefits described in the following sections of this Certificate: Supplemental Benefits; Outpatient Prescription Drug Program Benefits.

YOUR PROVIDER RELATIONSHIPS

The choice of a Hospital, Participating IPA, Participating Medical Group, Primary Care Physician or any other Provider is solely your choice and the Plan will not interfere with your relationship with any Provider.

The Plan does not itself undertake to provide health care services, but solely to arrange for the provision of health care services and to make payments to Providers for the Covered Services received by you. The Plan 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 the Plan. Any contractual relationship between a Physician and a Hospital or other Provider should not be construed to mean that the Plan is providing professional service.

Each Provider provides Covered Services only to Covered Persons and does not deal with or provide any services to any Group (other than as an individual Covered Person) or any Group's ERISA Health Benefit Program.

FAILURE OF YOUR PARTICIPATING IPA OR PARTICIPATING MEDICAL GROUP TO PERFORM UNDER ITS CONTRACT

Should your Participating IPA or Participating Medical Group fail to perform under the terms of its contract with the Plan, as determined by the Plan, or fail to renew such contract, the benefits of this Certificate will be provided for you for Covered Services received from other Providers limited to Covered Services received during a thirty day period beginning on the date of the Participating IPA's/Participating Medical Group's failure to perform or failure to renew its contract with the Plan. During this thirty day period, you will have the choice of transferring your enrollment to another Participating IPA or Participating Medical Group or of transferring your coverage to any other health care coverage then being offered by your Group to its members. Your transferred enrollment or coverage will be effective thirty-one days from the date your Participating IPA or Participating Medical Group failed to perform or failed to renew its contract with the Plan.

ENTIRE POLICY

The Group Policy, including the Certificate, any Addenda and/or Riders, the Benefit Program Application of the Group for the Policy and the individual ap-

plications, if any, of the Enrollees constitutes the entire contract of coverage between the Group and the Plan.

AGENCY RELATIONSHIPS

Your Group is your agent under this Certificate. Your Group is not the agent of the Plan.

NOTICES

Any information or notice which you furnish to the Plan under this Certificate must be in writing and sent to the Plan at its offices at 300 East Randolph Street, Chicago, Illinois, 60601-5099 (unless another address has been stated in this Certificate for a specific situation). Any information or notice which the Plan furnishes to you must be in writing and sent to you at your address as it appears on the Plan's records or in care of your Group and if applicable, in the case of a Qualified Medical Child Support Order, to the designated representative as it appears on the Plan's records.

LIMITATIONS OF ACTIONS

No legal action may be brought to recover under this Certificate until at least 60 days have elapsed since a Claim has been furnished to the Plan in accordance with the requirements of this Certificate. In addition, no such action may be brought once 3 years have elapsed from the date that a Claim is required to be furnished to the Plan in accordance with the requirements of this Certificate.

INFORMATION AND RECORDS

You agree that it is your responsibility to insure that any Provider, other Blue Cross and Blue Shield Plan, insurance company, employee benefit association, government body or program, any other person or entity, having knowledge of or records relating to (a) any illness or injury for which a Claim or Claims for benefits are made under this Certificate, (b) any medical history which might be pertinent to such illness, injury, Claim or Claims, or (c) any benefits or indemnification 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 the Plan or its agent, and agrees that any such Provider, person, or other entity may furnish to the Plan or its agent, 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, the Plan may furnish similar information and records (or copies of records) to Providers, other Blue Cross and Blue Shield Plans, insurance companies, governmental bodies or programs, or other entities providing insurance-type benefits requesting the same. It is also your responsibility to furnish the Plan and/or your employer or group administrator information regarding you or your dependents becoming eligible for Medicare, termination of Medicare eligibility, or any change in Medicare eligibility status, in order that the Plan be able to make Claim Payments in accordance with MSP laws.

DEFINITIONS

Throughout this Certificate, many words are used which have a specific meaning when applied to your health care coverage. The definitions of these words are listed below in alphabetical order. **These defined words will always be capitalized when used in this Certificate.**

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

Certificatemeans this booklet and your application for coverage under the Plan benefit program described in this booklet.

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

Certified Clinical Nurse Specialistmeans a nurse specialist who (a) is licensed under the Nursing and Advanced Practice Nursing Act; (b) has an arrangement or agreement with a Physician for obtaining medical consultation, collaboration and hospital referral and (c) meets the following qualifications:

- (i) is a graduate of an approved school of nursing and holds a current license as a registered nurse; and
- (ii) is a graduate of an advanced practice nursing program.

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

- (i) is a graduate of an approved school of nursing and holds a current license as a registered nurse; and
- (ii) is a graduate of a program of nurse-midwives accredited by the American College of Nurse Midwives or its predecessor.

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

- (i) is a graduate of an approved school of nursing and holds a current license as a registered nurse; and
- (ii) is a graduate of an advanced practice nursing program.

Certified Registered Nurse Anesthetist (CRNA)means a person 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.

Chemical Dependencymeans the uncontrollable or excessive abuse of addictive substances and the resultant physiological or psychological dependency which develops with continued use, requiring Medical Care as determined by a Physician or Psychologist. Addictive substances include, but are not limited to, alcohol, morphine, cocaine, heroin, opium, cannabis and other barbiturates, tranquilizers, amphetamines and/or hallucinogens.

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

Chemical Dependency Treatment Facilitymeans a facility (other than a Hospital) whose primary function is the treatment of Chemical Dependency and which 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.

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

Chiropractormeans a duly licensed chiropractor.

Claimmeans notification in a form acceptable to the Plan 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 the Plan may request in connection with services rendered to you.

Claim Chargemeans the amount which appears on a Claim as the Provider's or supplier's charge for goods or services furnished to you, without adjustment or reduction and regardless of any separate financial arrangement between the Plan and a particular Provider or supplier. (See provisions of this Certificate regarding "Plan's Separate Financial Arrangements with Providers.")

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

Clinical Appealmeans an appeal related to health care services, including, but not limited to, procedures or treatments ordered by a health care provider that do not meet the definition of an Urgent/Expedited Clinical Appeal.

COBRAmeans those sections of the Consolidated Omnibus Budget Reconciliation Act of 1985 P.L. 99-272, as amended which regulate the conditions and manner under which an employer can offer continuation of group health insurance to employees and their family members whose coverage would otherwise terminate under the terms of this Certificate.

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

Continuous Ambulatory Peritoneal Dialysis Treatmentmeans a continuous dialysis process using a patient's peritoneal membrane as a dialyzer.

Coverage Datemeans the date on which your coverage under this Certificate begins.

Covered Servicemeans a service or supply specified in this Certificate for which benefits will be provided.

Creditable Coveragemeans coverage you had under any of the following:

- a) A group health plan.
- b) Health insurance coverage for medical care under any hospital or medical service policy or certificate, hospital or medical service plan contract, or HMO contract offered by a health insurance issuer.
- c) Medicare (Parts A or B of Title XVIII of the Social Security Act).

- d) Medicaid (Title XIX of the Social Security Act).
- e) Medical care for members and certain former members of the uniformed services and their dependents.
- f) A medical care program of the Indian Health Service or of a tribal organization.
- g) A State health benefits risk pool.
- h) A health plan offered under the Federal Employees Health Benefits Program.
- i) A public health plan established or maintained by a State or any political subdivision of a State, the U.S. government or a foreign country.
- j) A health benefit plan under section 5(e) of the Peace Corps Act.
- k) State Children's Health Insurance Program (Title XXI of the Social Security Act).

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

Dentistmeans a duly licensed dentist.

Diagnostic Servicemeans tests performed to diagnose your condition because of your symptoms or to determine the progress of your illness or injury. Examples of these types of tests are x-rays, pathology services, clinical laboratory tests, pulmonary function studies, electrocardiograms, electroencephalograms, radioisotope tests and electromyograms.

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

Domestic Partnermeans a person with whom you have entered into a Domestic Partnership.

Domestic Partnershipmeans a long-term committed relationship of indefinite duration with a person which meets the following criteria:

- a) You and your Domestic Partner have lived together for at least six months;
- b) Neither you nor your Domestic Partner is married to anyone else or has another domestic partner;
- c) Both you and your Domestic Partner are at least 18 years of age and mentally competent to consent to contract ;
- d) You and your Domestic Partner reside together and intend to do so indefinitely;
- e) You and your Domestic Partner have an exclusive mutual commitment similar to marriage; and
- f) You and your Domestic Partner are jointly responsible for each other's common welfare and share financial obligations.

Electroconvulsive Therapymeans a medical procedure in which a brief application of an electric stimulus is used to produce a generalized seizure.

Emergency Conditionmeans an accidental bodily injury or a medical condition manifesting itself by acute symptoms of sufficient severity (including, but not limited to, severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- a) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- b) serious impairment to bodily functions; or
- c) serious dysfunction of any bodily organ or part.

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

Enrolleemeans the person who has applied for coverage under this Certificate and to whom the Plan has issued an identification card.

Enrollment Datemeans the first day of coverage under your Group's health plan or, if your Group has a waiting period prior to the effective date of your coverage, the first day of the waiting period (typically, the date employment begins).

Family Coveragemeans that your application for coverage was for yourself and other eligible members of your family.

Formulary Drugmeans a brand name prescription drug that has been designated as a preferred drug by the Plan. The listing of drugs designated as being Formulary Drugs may be amended from time to time by the Plan.

Hospice Care Programmeans a centrally administered program designed to provide physical, psychological, social and spiritual care for terminally ill persons and their families. The goal of hospice care is to allow the dying process to proceed with a minimum of patient discomfort while maintaining dignity and a quality of life. Hospice Care Program service is available in the home, or in Inpatient Hospital or-Skilled Nursing Facility special hospice care unit.

Hospice Care Program Providermeans an organization duly licensed to provide Hospice Care Program service.

Hospitalmeans a facility which is a duly licensed institution for the care of the sick which provides services under the care of a Physician including the regular provision of bedside nursing by registered nurses and which is either accredited by the Joint Commission on Accreditation of Hospitals or certified by the Social Security Administration as eligible for participation under Title XVIII, Health Insurance for the Aged and Disabled. It does not include health resorts, rest homes, nursing homes, custodial homes for the aged or similar institutions.

Individual Coveragemeans that your application for coverage was only for yourself.

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

Investigationalmeans procedures, drugs, devices, services and/or supplies which (a) 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 (b) 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 a covered person, and (c) specifically with respect to drugs, combination of drugs and/or devices, are not finally approved by the Food and Drug Administration at the time used or administered to the covered person.

Long Term Care Servicesmeans those social services, personal care services and/or Custodial Care Services needed by you when you have lost some capacity for self-care because of a chronic illness, injury or condition.

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

Maintenance Occupational Therapy, Maintenance Physical Therapy, and/or Maintenance Speech Therapymeans therapy administered to you to maintain a level of function at which no demonstrable and/or measurable improvement of a condition will occur.

Medical Caremeans the ordinary and usual professional services rendered by a Physician, or other specified Provider during a professional visit, for the treatment of an illness or injury.

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

Medicare Secondary Payer or MSPmeans those provisions of the Social Security Act set forth in 42 U.S.C. §1395 y (b), and the implementing regulations set forth in 42 C.F.R. Part 411, as amended, which regulate the manner in which certain employers may offer group health care coverage to Medicare-eligible employees, their spouses and, in some cases, dependent children.

Mental Illnessmeans those illnesses classified as mental disorders in the edition of 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-Clinical Appealmeans an appeal of non-clinical issues, such as appeals pertaining to benefits and administrative procedures.

Occupational Therapymeans a constructive therapeutic activity designed and adapted to promote the restoration of useful physical function.

Ongoing Course of Treatmentmeans the treatment of a condition or disease that requires repeated health care services pursuant to a plan of treatment by a Physician because of the potential for changes in the therapeutic regimen.

Optometristmeans a duly licensed optometrist.

Outpatientmeans that you are receiving treatment while not an Inpatient.

Partial Hospitalization Psychiatric Treatment Programmeans a Hospital's planned therapeutic treatment program, which has been approved by your Participating IPA or Participating Medical Group, in which patients with Mental Illness spend days or nights.

Participating IPAmeans any duly organized Individual Practice Association of Physicians which has a contract or agreement with the Plan to provide professional and ancillary services to persons enrolled under this benefit program.

Participating Medical Groupmeans any duly organized group of Physicians which has a contract or agreement with the Plan to provide professional and ancillary services to persons enrolled under this benefit program.

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

Physical Therapymeans the treatment by physical means by or under the supervision of a qualified physical therapist.

Physician Assistantmeans a duly licensed physician assistant performing under the direct supervision of a Physician.

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

PlanBlue Cross and Blue Shield of Illinois, a division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association of which HMO Illinois is a product line.

Podiatristmeans a duly licensed podiatrist.

Policymeans the agreement between the Plan and the Group, including the Certificate, any addenda or riders that apply, the Benefit Program Application of the Group and the individual applications, if any, of the persons covered under the Policy.

Prescription Drug Providermeans any Pharmacy which regularly dispenses drugs.

1. **Participating Prescription Drug Provider** means a Prescription Drug Provider which has entered into a written agreement with this Plan, or any entity designated by the Plan to administer its prescription drug program, to provide services to you at the time services are rendered to you and, for Pharmacies located in the state of Illinois, which has direct on-line computer access to the Plan or such administrative entity.
2. **Non-Participating Prescription Drug Provider** means a Prescription Drug Provider which does not meet the definition of a Participating Prescription Drug Provider.

Primary Care Physicianmeans a Provider who is a member or employee of or who is affiliated with or engaged by a Participating IPA or Participating Medical Group and who is a) a Physician who spends a majority of clinical time engaged in general practice or in the practice of internal medicine, pediatrics, gynecology, obstetrics or family practice, or b) a Chiropractor, and who you have selected to be primarily responsible for assessing, treating or coordinating your health care needs.

Private Duty Nursing Servicemeans Skilled Nursing Service provided on a one-to-one basis by an actively practicing registered nurse or licensed practical nurse. Private Duty Nursing Service does not include Custodial Care Service.

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

Provider's Chargemeans a) in the case of your Primary Care Physician or another Physician who is affiliated with your Participating IPA/Participating Medical Group, the amount that such Physician would have charged for a good or service had you not been enrolled under this benefit program or b) in the case of a Provider or supplier which is not affiliated with your Participating IPA/Participating Medical Group, such Provider's or supplier's Claim Charge for Covered Services but not to exceed the reasonable charge therefor as reasonably determined by the Plan. For the purposes of subsection b), the reasonable charge shall be determined by taking into consideration the Provider's or supplier's usual charge to others for the same good or service, the range of usual charges of other Providers or suppliers in a similar geographic area for the same good or service under similar or comparable circumstances and any extenuating or unusual circumstances that are relevant to the charge in a particular case.

Psychiatric Caremeans Medical Care rendered for the treatment of a Mental Illness. This type of care is limited to psychotherapy, group therapy, psychological testing and family therapy (joint sessions with family members and the patient).

Psychologistmeans:

- a) a Clinical Psychologist who is registered with the Illinois Department of Professional Regulation pursuant to the Illinois "Psychologist Registration Act" (111 Ill. Rev. Stat. §301 et seq., as amended or substituted); or
- b) in a state where statutory licensure exists, a Clinical Psychologist who holds a valid credential for such practice; or
- c) if practicing in a state where statutory licensure does not exist, a psychologist who specializes in the evaluation and treatment of Mental Illness and Chemical Dependency and who meets the following qualifications:
 1. 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 postdoctoral and one year in an organized health services program; or
 2. is a Registered Clinical Psychologist with a graduate degree from a regionally accredited University or College and has not less than six years experience as a psychologist with at least two years of supervised experience in health services.

Radiation Therapymeans the use of ionizing radiation in the treatment of a medical illness or condition.

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

Respite Care Servicesmeans those services provided at home or in a facility to temporarily relieve the family or other caregivers (non-professional personnel) that usually provide or are able to provide such services for you.

Skilled Nursing Facilitymeans 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.

Skilled Nursing Servicemeans those services provided by a registered nurse (R.N.) or licensed practical nurse (L.P.N.) which require the clinical 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. Benefits for Skilled Nursing Service will not be provided due to the lack of willing or available non-professional personnel. Skilled Nursing Service does not include Custodial Care Service.

Specialist Physicianmeans a Provider with a contractual relationship or affiliation with the Participating IPA/Participating Medical Group who does not meet the definition of a Primary Care Physician or Woman's Principal Health Care Provider.

Speech Therapymeans treatment for the correction of a speech impairment.

Standing Referralmeans a written referral from your Primary Care Physician or Woman's Principal Health Care Provider for an Ongoing Course of Treatment pursuant to a treatment plan specifying needed services and time frames as determined by your Primary Care Physician or Woman's Principal Health Care Provider, the consulting Physician or Provider and the Plan.

Surgerymeans 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 the Plan.

Totally Disabledmeans, with respect to an Eligible Person, an inability by reason of illness or injury to perform his regular or customary occupational duties or, with respect to a covered person other than the Eligible Person, the in-

ability by reason of illness, injury or physical condition to engage in the normal activities of a person of the same age and sex who is in good health.

Urgent/Expedited Clinical Appealmeans an appeal of a clinically urgent nature that relates to health care services, including, but not limited to, procedures or treatments ordered by a health care provider that, if a decision is denied, may significantly increase the risk to your health.

Usual And Customary Feemeans the fee as reasonably determined by the Plan which is based on the fee which the Provider who renders the service usually charges its patients for the same service and the fee which is within the range of usual fees other Providers of similar type, training and experience in a similar geographic area charge their patients for the same service, under similar or comparable circumstances.

Woman's Principal Health Care Providermeans a physician licensed to practice medicine in all of its branches, specializing in obstetrics or gynecology or specializing in family practice.

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