Filing at a Glance

Company:	Health Care Service Corporation
Product Name:	HCSC ET BCBS AR-IL
State:	Arkansas
TOI:	H16G Group Health - Major Medical
Sub-TOI:	H16G.001A Any Size Group - PPO
Filing Type:	Form
Date Submitted:	08/06/2012
SERFF Tr Num:	CMPL-128083638
SERFF Status:	Closed-Approved-Closed
State Tr Num:	
State Status:	Approved-Closed
Co Tr Num:	HCSC ET BCBS AR-IL
Implementation Date Requested:	On Approval
Author(s):	Nancy French
Reviewer(s):	Rosalind Minor (primary)
Disposition Date:	08/08/2012
Disposition Status:	Approved-Closed
Implementation Date:	

State Filing Description:

State: *Arkansas* **Filing Company:** *Health Care Service Corporation*
TOI/Sub-TOI: *H16G Group Health - Major Medical/H16G.001A Any Size Group - PPO*
Product Name: *HCSC ET BCBS AR-IL*
Project Name/Number: *HCSC ET BCBS AR-IL/HCSC ET BCBS AR-IL*

General Information

Project Name: HCSC ET BCBS AR-IL
Project Number: HCSC ET BCBS AR-IL
Requested Filing Mode: Informational
Explanation for Combination/Other:
Submission Type: New Submission
Group Market Type: Employer
Filing Status Changed: 08/08/2012
State Status Changed: 08/08/2012
Created By: Nancy French
Corresponding Filing Tracking Number:

Status of Filing in Domicile:
Date Approved in Domicile:
Domicile Status Comments:
Market Type: Group
Group Market Size: Large
Overall Rate Impact:

Deemer Date:
Submitted By: Nancy French

PPACA: Non-Grandfathered Immed Mkt Reforms, Grandfathered Immed Mkt Reforms

PPACA Notes: null

Filing Description:
Please find cover letter under the supporting doucmentation tab.

Company and Contact

Filing Contact Information

Nancy French, Product Manager
10921 Reed Hartman Highway
Suite 334
Cincinnati, OH 45242

nfrench@crssolutionsgroup.com
513-984-6050 [Phone]
513-984-7212 [FAX]

Filing Company Information

(This filing was made by a third party - complianceresearchservicesllc)

Health Care Service Corporation
300 East Randolph Street
Chicago, IL 60601
(513) 984-6050 ext. [Phone]

CoCode: 70670
Group Code: 917
Group Name:
FEIN Number: 36-1236610

State of Domicile: Illinois
Company Type:
State ID Number:

Filing Fees

Fee Required? Yes
Fee Amount: $150.00
Retaliatory? No
Fee Explanation: 50 x 3 forms = $150.00
Per Company: No

Company	Amount	Date Processed	Transaction #
Health Care Service Corporation	$150.00	08/06/2012	61447365

State: Arkansas **Filing Company:** Health Care Service Corporation
TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.001A Any Size Group - PPO
Product Name: HCSC ET BCBS AR-IL
Project Name/Number: HCSC ET BCBS AR-IL/HCSC ET BCBS AR-IL

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	08/08/2012	08/08/2012

State: *Arkansas* **Filing Company:** *Health Care Service Corporation*
TOI/Sub-TOI: *H16G Group Health - Major Medical/H16G.001A Any Size Group - PPO*
Product Name: *HCSC ET BCBS AR-IL*
Project Name/Number: *HCSC ET BCBS AR-IL/HCSC ET BCBS AR-IL*

Disposition

Disposition Date: 08/08/2012
Implementation Date:
Status: Approved-Closed
HHS Status: HHS Approved
State Review: Reviewed-No Actuary
Comment:

Rate data does NOT apply to filing.

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	PPACA Uniform Compliance Summary	Approved-Closed	Yes
Supporting Document	Authorization	Approved-Closed	Yes
Supporting Document	AR_AR Certif of Compliance with Rule 19	Approved-Closed	Yes
Supporting Document	AR BCBSIL Certification of Benefit Differential	Approved-Closed	Yes
Supporting Document	Cover Letter	Approved-Closed	Yes
Form	Extraterritorial Benefits Rider	Approved-Closed	Yes
Form	Certificate – BCBS of Illinois	Approved-Closed	Yes
Form	Group Certificate Rider/PPACA and other	Approved-Closed	Yes

State: *Arkansas* **Filing Company:** *Health Care Service Corporation*
TOI/Sub-TOI: *H16G Group Health - Major Medical/H16G.001A Any Size Group - PPO*
Product Name: *HCSC ET BCBS AR-IL*
Project Name/Number: *HCSC ET BCBS AR-IL/HCSC ET BCBS AR-IL*

Form Schedule

Lead Form Number: ETGB-SC-HCSC-2012

Item No.	Schedule Item Status	Form Number	Form Type	Form Name	Action/ Action Specific Data	Readability Score	Attachments
1	Approved-Closed 08/08/2012	ETGB-AR-HCSC-2012	CERA	Extraterritorial Benefits Rider	Initial:	42.300	_ET_AR.pdf
2	Approved-Closed 08/08/2012	GB-10-1 HCSC	CER	Certificate – BCBS of Illinois	Initial:	41.000	IL Insured Certificate Master.pdf
3	Approved-Closed 08/08/2012	GB-10-A184 HCSC	CERA	Group Certificate Rider/PPACA and other	Initial:	40.900	GB-10-A184 Rev 201012.pdf

Form Type Legend:

ADV	Advertising	**AEF**	Application/Enrollment Form
CER	Certificate	**CERA**	Certificate Amendment, Insert Page, Endorsement or Rider
DDP	Data/Declaration Pages	**FND**	Funding Agreement (Annuity, Individual and Group)
MTX	Matrix	**NOC**	Notice of Coverage
OTH	Other	**OUT**	Outline of Coverage
PJK	Policy Jacket	**POL**	Policy/Contract/Fraternal Certificate
POLA	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	**SCH**	Schedule Pages

RIDER FOR RESIDENTS OF THE STATE OF ARKANSAS

If you reside permanently in the state of Arkansas, the [Certificate][Benefit Booklet] to which this [rider][Rider] is attached and becomes a part is amended as stated below to conform to the requirements of the state of Arkansas. In the event of a conflict between the [Certificate][Benefit Booklet] and this [rider][Rider], the provisions resulting in greater [benefits][Benefits] will be in effect.

1. **Individual and Family Eligibility**

   The eligibility provision outlining a change in coverage from [individual coverage][Individual Coverage] to [family coverage][Family Coverage] is changed as follows:

   If you apply for a change from [individual coverage][Individual Coverage] to [family coverage][Family Coverage] within 90 days of the birth or within 60 days of the adoption or [placement for adoption][Placement for Adoption] of a [child][Child], your [family coverage][Family Coverage] will be effective from the date of the birth, adoption or [placement for adoption][Placement for Adoption].

   If you do not apply for [family coverage][Family Coverage] within 90 days of the birth or within 60 days of the adoption or [placement for adoption][Placement for Adoption] of a [child][Child], you can make application at any time. The change will be effective on a date that has been mutually agreed to by your [group][Group] and [Blue Cross and Blue Shield of Illinois][Blue Cross and Blue Shield of Texas][Blue Cross and Blue Shield of New Mexico][Blue Cross and Blue Shield of Oklahoma].

2. **Family Coverage**

   The eligibility provision concerning adding [dependents][Dependents] to [family coverage][Family Coverage] is changed as follows**:**

   If you apply to add your newborn [child][Child] to your [family coverage][Family Coverage] within 90 days of the [child's][Child's] birth or to add your adopted [child][Child] or [child][Child] placed for adoption to your [family coverage][Family Coverage] within 60 days of the adoption or [placement for adoption][Placement for Adoption], coverage for your [dependent][Dependent]will be effective from the date of the birth, adoption or [placement for adoption][Placement for Adoption].

   If you do not apply to add your newborn within 90 days of the birth, or your adopted [child][Child] within 60 days of the adoption or [placement for adoption][Placement for Adoption], you can make application at any time. The change will be effective on a date that has been mutually agreed to by your [group][Group] and [Blue Cross and Blue Shield of Illinois][Blue Cross and Blue Shield of Texas][Blue Cross and Blue Shield of New Mexico][Blue Cross and Blue Shield of Oklahoma].

3. Mentally and Physically Handicapped Children

Benefits are provided for your [dependent][Dependent] [child][Child] after they reach the limiting age if the [dependent][Dependent] [child][Child] is incapable of self–sustaining employment by reason of mental or physical handicap; became incapacitated prior to the attainment of age 19; and is chiefly dependent on you for support and maintenance. Proof of the incapacity and dependency must be furnished to [Blue Cross and Blue Shield of Illinois][Blue Cross and Blue Shield of Texas][Blue Cross and Blue Shield of New Mexico][Blue Cross and Blue Shield of Oklahoma].

4. Providers

Benefits for the following [providers][Providers] will be paid at the same level as other [providers][Providers].

- [Advanced practice nurses][Advanced Practice Nurses].
- Athletic trainers.
- [Audiologists][Licensed Audiologists].
- Certified orthotists.
- [Chiropractors][Doctors of Chiropractic].
- Community mental health centers or clinics.
- [Dentists][Doctors of Dentistry]
- [Home health care][Home Health Care][Coordinated Home Care].
- Hospice care.
- Hospital–based service.
- Hospitals.
- Licensed ambulatory surgery centers.
- Licensed [social workers][Clinical Social Workers].
- Licensed [dieticians][Dieticians].
- Licensed [professional counselors][Professional Counselors].
- Licensed psychological examiners.
- Long–term care facilities
- Nurse Anesthetists
- [Occupational therapists][Licensed Occupational Therapists][Occupational Therapists].
- Optometrists.

- Pharmacists.
- [Physical therapists][Licensed Physical Therapists][Physical Therapists].
- Physicians and surgeons (M.D. and D.O.).
- [Podiatrists][Doctors of Podiatry].
- Prostheticists.
- [Psychologists][Doctors of Psychology].
- Respiratory therapists.
- Rural health clinics; and
- [Speech pathologists][Licensed Speech–Language Pathologists].

In addition, benefits will be provided for non–[hospital][Hospital] based medical facilities providing clinical diagnostic services for sleep disorder, and non–[hospital][Hospital] based medical [facilities][Facilities] providing magnetic resonance imaging, computed axial tomography, or other imaging diagnostic testing.

5. Well Child Care

Benefits will be provided for [Covered Charges][Allowable Charges][Allowable Amounts][Eligible Charges][eligible expenses] rendered by a [physician][Physician] to [children][Children] under age 19, even though they are not ill. Benefits will be limited to the following services:

- Immunizations;
- Routine diagnostic tests;
- 20 physical examinations at approximately the following age intervals:
    - Birth,
    - Two weeks,
    - Two months,
    - Four months,
    - Six months,
    - Nine months,
    - 12 months,
    - 15 months,
    - 18 months,

- Two years,
- Three years,
- Four years,
- Five years,
- Six years,
- Eight years,
- 10 years,
- 12 years,
- 14 years,
- 16 years, and
- 18 years.

Benefits will not be subject to any [copayment][Copayment][Copayment Amount], [deductible][Deductible], [coinsurance][Coinsurance][Coinsurance Amount] or [benefit period][Benefit Period] dollar maximum.

6. Mammograms

If your [group][Group] elects to cover mammograms, benefits will be provided as follows:

- A base line mammogram for a female who is at least 35 years of age but less than 40 years of age;
- One mammogram every one to two years for a female who is from 40 to 49 years of age; and
- One mammogram a year for a female who is at least 50 years of age; or
- A mammogram upon recommendation of a woman's [physician][Physician], without regard to age, when the woman has had a prior history of breast cancer or when the woman's mother or sister has had a history of breast cancer.

Benefits are not subject to a [deductible][Deductible],[copayment][Copayment][Copayment Amount] or the [coinsurance][Coinsurance][Coinsurance Amount].

7. Colorectal Cancer

Benefits will be provided for colorectal cancer examinations as follows:

- If you are more than 50 years of age;
- If you are age 50 and under and are at high risk for colorectal cancer according to the American Cancer Society colorectal cancer screening guidelines; or

- If you are experiencing bleeding from the rectum or blood in the stool, or if you have a change in bowel habits such as diarrhea, constipation or narrowing of the stool that lasts for more than five days.

Colorectal screening shall involve an examination of the entire colon including the following:

- An annual fecal occult blood test utilizing the take–home multiple sample method, or an annual fecal immunochemical test in conjunction with a flexible sigmoidoscopy every five years;
- A double–contrast barium enema every five years; or
- A colonoscopy every ten years; and
- Any additional medically recognized screening tests for colorectal cancer required the Director of the Department of Health.

Benefits are not subject to a [deductible][Deductible],[copayment][Copayment][Copayment Amount] or the [coinsurance][Coinsurance][Coinsurance Amount].

8. Prostate Cancer

Benefits will be provided for at least one screening per year for any man 40 years of age or older according to the National Comprehensive Cancer Network guidelines. Benefits are not subject to a [deductible][Deductible],[copayment][Copayment][Copayment Amount] or the [coinsurance][Coinsurance][Coinsurance Amount].

9. Phenylketonuria Treatment

Benefits will be provided for amino acid modified preparations, low protein modified food products and any other special dietary products and formulas prescribed by a [physician][Physician] for the therapeutic treatment of phenylketonuria, galactosemia, organic acidemias, and disorders of amino acid metabolism.

10. Musculoskeletal Disorders

Benefits will be provided for the surgical and non–surgical treatment of musculoskeletal disorders affecting any bone or joint in the face, neck or head including [temporomandibular joint syndrome][temporomandibular joint dysfunction][Temporomandibular Joint Dysfunction]] and craniomandibular disorder. Your [benefits][Benefits] for musculoskeletal disorders are the same as your [benefits][Benefits] for any other condition.

11. In Vitro Fertilization

Benefits will be provided for in vitro fertilization procedures for you or your [dependent][Dependent] spouse when:

- Your or your spouse's oocytes are fertilized with the sperm of you or your spouse, and

- You or your spouse have a history of unexplained infertility of at least two years duration; or
- The infertility is associated with one or more of the following medical conditions:
    - Endometriosis;
    - Exposure in utero to diethylstilbestrol, commonly known as DES;
    - Blockage of or removal of one or both fallopian tubes that is not a result of voluntary sterilization; or
    - Abnormal male factors contributing to the infertility.
- The in vitro fertilization procedures are performed at a [facility][Facility] licensed or certified by the Arkansas Department of Health which conforms to the standards of the American College of Obstetricians and Gynecologists', or are performed at a [facility][Facility] certified by the Arkansas Department of Health which meet the American Fertility Society's minimal standards for programs of in vitro fertilization.
- You or your spouse has been unable to obtain successful pregnancy through any less costly infertility treatment for which coverage is available under the [group health plan][Group Health Plan][Group Policy][Health Benefit Plan].

The [benefits][Benefits] for in vitro fertilization are the same as the [benefits][Benefits] provided under [maternity][Maternity] [benefit][Benefit] provisions. Cryopreservation, the procedure whereby embryos are frozen for late implantation, is included as an in vitro fertilization procedure.

12. Diabetes Supplies and Training

The provision related to the treatment of diabetes is revised to provide [benefits][Benefits] for blood glucose monitors, blood glucose monitors for the legally blind, test strips (for monitors, glucose control solutions, lancet devices and lancets), visual reading and urine testing strips, insulin, injection aids, syringes, insulin pumps an supplies (such as skin preparations, adhesive supplies, infusion sets, cartridge and batteries) oral agents for controlling blood sugar, podiatric appliances for prevention of complications associated with diabetes (including therapeutic molded or depth–inlay shoes, replacement inserts, preventive devices and shoe modifications for prevention and treatment) and glucagon emergency kits. In addition, [benefits][Benefits] will be provided for [inpatient][Inpatient] and [outpatient][Outpatient] self–management training and education, including medical nutrition therapy, relating to diet, caloric intake and diabetes management but excluding programs the primary purposes of which are weight reduction.

13. Maternity Care

The coverage for [Maternity Services][Maternity Care][maternity care] is changed to allow [routine nursery care][Routine Nursery Care] and pediatric charges for a well newborn [child][Child] for up to five full days in a [hospital][Hospital] nursery or until the mother is discharged from the [hospital][Hospital] following the birth.

14. Cancer Treatment

Benefits will be provided for drugs used for the treatment of cancer if:

- The drug has been approved by the federal Food and Drug Administration for the treatment of the specific type of cancer for which it has been prescribed; and
- The drug is recognized for treatment of that specific type of cancer in one of the standard reference compendia or in the medical literature.

15. Hearing Aids

Benefits will be provided for a hearing aid or hearing instrument sold by a licensed professional. The coverage for hearing aids shall be for not less than $1,400 per ear, and is not subject to [deductibles][Deductibles] or [copayments][Copayments][Copayment Amounts].

16. Anesthesia and Dental Procedures

Benefits will be provided for anesthesia, [hospital][Hospital] or [ambulatory surgical facility][Ambulatory Surgical Facility] charges for dental procedures if it is certified that general anesthesia is required to safely perform the procedures and the patient is:

- A [child][Child] under seven years of age who is determined by two licensed [dentists][Dentists] to require without delay necessary dental treatment in a [hospital][Hospital] or [ambulatory surgical facility][Ambulatory Surgical Facility] for a significantly complex dental condition;
- A person with a diagnosed serious physical condition or [mental illness][Mental Illness][Mental Health Care disorder]; or
- A person with a significant behavioral problem as determined by your [physician][Physician].

17. Contraceptive Drugs and Devices

If your coverage provides benefits for prescription drugs on [outpatient][Outpatient] basis, then [benefits][Benefits] will be provided for [prescription drugs][Prescription Drugs] or devices approved by the United States Food and Drug Administration for use as a contraceptive. A religious organization is not required to provide this [benefit][Benefit]. A “religious employer” means an entity that: (1) is organized and

operated for religious purposes and has received a section 501(c)(3) designation from the Internal Revenue Service; (2) has as one of its primary purposes the inculcation of religious values; and (3) employs primarily persons who share its religious tenets.

18. Late Claim Payments

The interest rate for a [claim][Claim] not paid on time by the claim administrator is 12%.

19. Continuation of Coverage

If you have been insured continuously under this [group health plan][Group Health Plan][Group Policy][Health Benefit Plan] for at least three months and your coverage has been terminated for any reason other than nonpayment of the required contribution, you may continue coverage under this [group health plan][Group Health Plan][Group Policy][Health Benefit Plan] for an additional three months. You must request continuation in writing no later than 10 days after the termination of employment or membership or a change in marital status. You must pay the entire premium including any portion paid by your former [group][Group]. Continuation of coverage is subject to the [group health plan][Group Health Plan][Group Policy][Health Benefit Plan] or a successor [group health plan][Group Health Plan][Group Policy][Health Benefit Plan] remaining in force.

Continuation of coverage shall end at the earliest of the following dates:

- 120 days after continuation of coverage begins;
- The end of the period for which the individual made a timely contribution;
- The contribution due date following the date the individual becomes eligible for Medicare; or
- The date on which the [policy][contract] is terminated or the [group][Group] withdraws from the [group health plan][Group Health Plan][Group Policy][Health Benefit Plan].

20. Conversion Privilege

If your coverage under this [group health plan][Group Health Plan][Group Policy][Health Benefit Plan] should terminate for any reason, including the discontinuance of the [group health plan][Group Health Plan][Group Policy][Health Benefit Plan] in its entirety, and you want to continue [Blue Cross and Blue Shield of Illinois][Blue Cross and Blue Shield of Texas][Blue Cross and Blue Shield of New Mexico][Blue Cross and Blue Shield of Oklahoma] coverage with no interruption, you may do so if your [group][Group] has not cancelled this coverage and replaced it with other coverage. Here is what to do:

1. Tell [Blue Cross and Blue Shield of Illinois][Blue Cross and Blue Shield of Texas][Blue Cross and Blue Shield of New Mexi-

co][Blue Cross and Blue Shield of Oklahoma] or your [group][Group] administrator that you wish to continue your coverage and you will be provided with the necessary application.

2. Send the application and first premium to [Blue Cross and Blue Shield of Illinois][Blue Cross and Blue Shield of Texas][Blue Cross and Blue Shield of New Mexico][Blue Cross and Blue Shield of Oklahoma] within 31 days of the date you leave your [group][Group] or within 15 days after you have been given written notice of the conversion privilege, but in no event later than 60 days after you leave your [group][Group].

Having done so, you will then be covered by [Blue Cross and Blue Shield of Illinois][Blue Cross and Blue Shield of Texas][Blue Cross and Blue Shield of New Mexico][Blue Cross and Blue Shield of Oklahoma] on an individual "direct pay" basis. This coverage will be effective from the date your coverage under this [group health plan][Group Health Plan][Group Policy][Health Benefit Plan] terminates so long as the premiums charged for the direct pay coverage are paid when due.

These direct pay [benefits][Benefits] (and the premium charged for them) may not be exactly the same as the [benefits][Benefits] under the [group health plan][Group Health Plan][Group Policy][Health Benefit Plan]. However, by converting your coverage, your [benefits][Benefits] under the [group health plan][Group Health Plan][Group Policy][Health Benefit Plan] are not interrupted and you will not have to repeat [waiting periods][Waiting Periods] (if any).

[Should any or all of your [dependents][Dependents] become ineligible for coverage under this [group health plan][Group Health Plan][Group Policy][Health Benefit Plan], they may convert to direct pay coverage by following the instructions stated above.]

3. Coordination of Benefits

DEFINITIONS

A. A [group health plan][Group Health Plan][Group Policy][Health Benefit Plan] is any of the following that provides [benefits][Benefits] or services for medical or dental care or treatment. If separate [contracts][Contracts] are used to provide coordinated coverage for [members][Members] of a [group][Group], the separate [contracts][Contracts] are considered parts of the same [group health plan][Group Health Plan][Group Policy][Health Benefit Plan] and there is no coordination of benefits (COB) among those separate [contracts][Contracts].

(1) A [group health plan][Group Health Plan][Group Policy][Health Benefit Plan] includes: [group][Group] and nongroup [contracts][Contracts], [health maintenance organization][Health Maintenance Organization] (HMO) [contracts][Contracts], closed panel

plans or other forms of [group][Group] coverage (whether insured or uninsured); [medical care][Medical Care] components of [long term care][Long Term Care] [contracts][Contracts], such as [skilled nursing care][Skilled Nursing Care]; medical benefits under [group][Group] or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.

(2) A [group health plan][Group Health Plan][Group Policy][Health Benefit Plan] does not include: [hospital][Hospital] indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefits for non–medical components of [long term care][Long Term Care] policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law. Each [contract][Contract] for coverage under (1) or (2) is a separate [group health plan][Group Health Plan][Group Policy][Health Benefit Plan]. If a [group health plan][Group Health Plan][Group Policy][Health Benefit Plan] has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate [group health plan][Group Health Plan][Group Policy][Health Benefit Plan].

B. This [group health plan][Group Health Plan][Group Policy][Health Benefit Plan] means, in a COB provision, the part of the [contract][Contract] providing the health care benefits to which the COB provision applies and which may be reduced because of the [benefits][Benefits] of other [group health plan][Group Health Plan][Group Policy][Health Benefit Plan]. Any other part of the [contract][Contract] providing health care benefits is separate from this [group health plan][Group Health Plan][Group Policy][Health Benefit Plan]. A [contract][Contract] may apply one COB provision to certain [benefits][Benefits], such as dental [benefits][Benefits], coordinating only with similar [benefits][Benefits], and may apply another COB provision to coordinate other [benefits][Benefits].

C. The order of [benefit][Benefit] determination rules determine whether this [group health plan][Group Health Plan][Group Policy][Health Benefit Plan] is a primary plan or secondary plan when the person has health care coverage under more than one [group health plan][Group Health Plan][Group Policy][Health Benefit Plan]. When this [group health plan][Group Health Plan][Group Policy][Health Benefit Plan] is primary, it determines payment for its [benefits][Benefits] first before those of any other [group health plan][Group Health Plan][Group Policy][Health Benefit Plan] without considering any other [group health plan's][Group Health Plan's][Group Policy's][Health Benefit Plan's] [benefits][Benefits]. When this [group health plan][Group Health Plan][Group Policy][Health Benefit Plan] is secondary, it determines its [benefits][Benefits] after those

of another [group health plan][Group Health Plan][Group Policy][Health Benefit Plan] and may reduce the [benefits][Benefits] it pays so that all [benefits][Benefits] do not exceed 100% of the total allowable expense.

D. Allowable expense is a health care expense, including [deductibles][Deductibles], [coinsurance][Coinsurance][Coinsurance Amounts] and [copayments][Copayments][Copayment Amounts], that is covered at least in part by any [group health plan][Group Health Plan][Group Policy][Health Benefit Plan] covering the person. When a [group health plan][Group Health Plan][Group Policy][Health Benefit Plan] provides [benefits][Benefits] in the form of services, the reasonable cash value of each service will be considered an allowable expense and a [benefit][Benefit] paid. An expense that is not covered by any [group health plan][Group Health Plan][Group Policy][Health Benefit Plan] covering the person is not an allowable expense. In addition, any expense that a [provider][Provider] by law or in accordance with a contractual agreement is prohibited from charging a covered person is not an allowable expense. The following are examples of expenses that are not allowable expenses:

(1) The difference between the cost of a semi–private [hospital][Hospital] room and a private [hospital][Hospital] room is not an allowable expense, unless one of the [group health plan][Group Health Plan][Group Policy][Health Benefit Plan] provides coverage for private [hospital][Hospital] room expenses.

(2) If a person is covered by two or more [group health plan][Group Health Plan][Group Policy][Health Benefit Plan] that compute their [benefit][Benefit] payments on the basis of [usual and customary][Usual and Customary] fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific [benefit][Benefit] is not an allowable expense.

(3) If a person is covered by two or more [group health plan][Group Health Plan][Group Policy][Health Benefit Plan] that provide [benefits][Benefits] or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an allowable expense.

(4) If a person is covered by one [group health plan][Group Health Plan][Group Policy][Health Benefit Plan] that calculates its [benefits][Benefits] or services on the basis of [usual and customary][Usual and Customary] fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another [group health plan][Group Health Plan][Group Policy][Health Benefit Plan] that provides its [benefits][Benefits] or services on the basis of negotiated fees, the primary plan's payment

arrangement shall be the allowable expense for all [group health plans][Group Health Plans][Group Policies][Health Benefit Plans]. However, if the [provider][Provider] has contracted with the secondary plan to provide the [benefit][Benefit] or service for a specific negotiated fee or payment amount that is different than the primary plan's payment arrangement and if the [provider's][Provider's] [contract][Contract] permits, the negotiated fee or payment shall be the allowable expense used by the secondary plan to determine its [benefits][Benefits].

(5) The amount of any [benefit][Benefit] reduction by the primary plan because a covered person has failed to comply with the [group health plan][Group Health Plan][Group Policy][Health Benefit Plan] provisions is not an allowable expense. Examples of these types of plan provisions include second surgical opinions, [preadmission review][precertification][Precertification]Preauthorization] of [admissions][Admissions], and [preferred provider][Preferred Provider] arrangements.

ORDER OF BENEFIT DETERMINATION RULES

When a person is covered by two or more [group health plans][Group Health Plans][Group Policies][Health Benefit Plans], the rules for determining the order of [benefit][Benefit] payments are as follows:

A. The primary plan pays or provides its [benefits][Benefits] according to its terms of coverage and without regard to the [benefits][Benefits] under any other [group health plan][Group Health Plan][Group Policy][Health Benefit Plan].

B. (1) Except as provided in Paragraph (2), a [group health plan][Group Health Plan][Group Policy][Health Benefit Plan] that does not contain a coordination of benefits provision that is consistent with this regulation is always primary unless the provisions of both [group health plan][Group Health Plan][Group Policy][Health Benefit Plan] state that the complying [group health plan][Group Health Plan][Group Policy][Health Benefit Plan] is primary.

(2) Coverage that is obtained by virtue of membership in a [group][Group] that is designed to supplement a part of a basic package of [benefits][Benefits] and provides that this supplementary coverage shall be excess to any other parts of the [group health plans][Group Health Plans][Group Policies][Health Benefit Plans] provided by the [contract][Contract] holder. Examples of these types of situations are major medical coverages that are superimposed over base plan [hospital][Hospital] and surgical [benefits][Benefits], and insurance type coverages that are written in connection with a closed panel plan to provide [out–of–network][Out–of–Network] [benefits][Benefits].

EFFECT ON THE BENEFITS OF THIS PLAN

A. When this [group health plan][Group Health Plan][Group Policy][Health Benefit Plan] is secondary, it may reduce its [benefits][Benefits] so that the total [benefits][Benefits] paid or provided by all [group health plans][Group Health Plans][Group Policies][Health Benefit Plans] during a plan year are not more than the total allowable expenses. In determining the amount to be paid for any [claim][Claim], the secondary plan will calculate the [benefits][Benefits] it would have paid in the absence of other health care coverage and apply that calculated amount to any allowable expense under its [group health plan][Group Health Plan][Group Policy][Health Benefit Plan] that is unpaid by the primary plan. The secondary plan may then reduce its payment by the amount so that, when combined with the amount paid by the primary plan, the total [benefits][Benefits] paid or provided by all [benefits][Benefits] for the [claim][Claim] do not exceed the total allowable expense for that [claim][Claim]. In addition, the secondary plan shall credit to its plan [deductible][Deductible] any amounts it would have credited to its [deductible][Deductible] in the absence of other health care coverage.

B. If a covered person is enrolled in two or more closed panel plans and if, for any reason, including the provision of service by a non–panel Provider, [benefits][Benefits] are not payable by one closed panel plan, COB shall not apply between that [group health plan][Group Health Plan][Health Benefit Plan] and other closed panel plans.

FACILITY OF PAYMENT

A payment made under another [group health plan][Group Health Plan][Group Policy][Health Benefit Plan] may include an amount that should have been paid under this [group health plan][Group Health Plan][Group Policy][Health Benefit Plan]. If it does, [Blue Cross and Blue Shield of Illinois][Blue Cross and Blue Shield of Texas][Blue Cross and Blue Shield of New Mexico][Blue Cross and Blue Shield of Oklahoma] may pay that amount to the organization that made that payment. That amount will then be treated as though it were a [benefit][Benefit] paid under this [group health plan][Group Health Plan][Group Policy][Health Benefit Plan]. [Blue Cross and Blue Shield of Illinois][Blue Cross and Blue Shield of Texas][Blue Cross and Blue Shield of New Mexico][Blue Cross and Blue Shield of Oklahoma] will not have to pay that amount again. The term "payment made" includes providing [benefits][Benefits] in the form of services, in which case "payment made" means the reasonable cash value of the [benefits][Benefits] provided in the form of services.

RIGHT OF RECOVERY

If the amount of the payments made by [Blue Cross and Blue Shield of Illinois][Blue Cross and Blue Shield of Texas][Blue Cross and Blue Shield of New Mexico][Blue Cross and Blue Shield of Oklahoma] is

more than it should have paid under this COB provision, it may recover the excess from one or more of the persons it has paid or for whom it has paid; or any other person or organization that may be responsible for the [benefits][Benefits] or services provided for the covered person. The "amount of the payments made" includes the reasonable cash value of any [benefits][Benefits] provided in the form of services.

Except as amended by this [rider][Rider], all terms, conditions, limitations and exclusions of the [Certificate][Benefit Booklet] to which this [rider][Rider] is attached will remain in full force and effect.

[Attest:

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

Thomas C. Lubben
Secretary

Patricia A. Hemingway Hall
President]

Your Health Care Benefit Program

Your Dental Care Benefit Program

Your Prescription Drug Benefit Program

This booklet is your Certificate of HealthDental Care Benefits. It describes the healthdental care benefit program that we have arranged for you. This program is underwritten by Health Care Service Corporation, a Mutual Legal Reserve Company, the Blue Cross and Blue Shield Plan serving the state of Illinois.

We are pleased to offer this program to you and your family. We believe it will help relieve you of many financial worries should you have healthdental care expenses.

Sincerely, 0.11

A message from

BLUE CROSS AND BLUE SHIELD

Your Group has entered into an agreement with us (Health Care Service Corporation, a Mutual Legal Reserve Company, the Blue Cross and Blue Shield Plan serving the state of Illinois) to provide you with this benefit program. Like most people, you probably have many questions about your coverage. This Certificate contains a great deal of information about the services and supplies for which benefits will be provided under your benefit program. Please read your entire Certificate very carefully. We hope that most of the questions you have about your coverage will be answered.

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

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,

Patricia A. Hemingway Hall
President

Deborah Dorman-Rodriguez
Secretary

NOTICE

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

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

[Please note that Blue Cross and Blue Shield of Illinois has contracts, either directly or indirectly, with many prescription drug providers that provide for Blue Cross and Blue Shield to receive, and keep for its own account, payments, discounts and/or allowances with respect to the bill for services you receive from those providers.

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

[WARNING, LIMITED BENEFITS WILL BE PAID WHEN NON-PARTICIPATING PROVIDERS ARE USED

You should be aware that when you elect to utilize the services of a Non-Participating Provider for a Covered Service in non-emergency situations, benefit payments to such Non-Participating Provider are not based upon the amount billed. The basis of your benefit payment will be determined according to your policy's fee schedule, usual and customary charge (which is determined by comparing charges for similar services adjusted to the geographical area where the services are performed), or other method as defined by the policy. YOU CAN EXPECT TO PAY MORE THAN THE COINSURANCE AMOUNT DEFINED IN THE POLICY AFTER THE PLAN HAS PAID ITS REQUIRED PORTION. Non-Participating Providers may bill members for any amount up to the billed charge after the plan has paid its portion of the bill. Participating Providers have agreed to accept discounted payments for services with no additional billing to the member other than Coinsurance and deductible amounts. You may obtain further information about the participating status of professional providers and information on out-of-pocket expenses by calling the toll free telephone number on your identification card.]

TABLE OF CONTENTS

BENEFIT HIGHLIGHTS

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

THE MEDICAL SERVICES ADVISORY PROGRAM MSA®′ Registered Mark of Health Care Service Corporation a Mutual Legal Reserve Company	A special program designed to assist you in determining the course of treatment that will maximize your benefits under this Certificate	0.418
UTILIZATION REVIEW PROGRAM	A special program designed to assist you in determining the course of treatment that will maximize your benefits under this Certificate	
PLAN HOSPITAL BENEFITS		0.4101
Inpatient Covered Services		
— Deductible per benefit period	$ per individual	0.41011
— Benefit Payment Level	1st $ per benefit period at the Eligible Charge, then % of the Eligible Charge	0.41012
Outpatient Covered Services	% of the Eligible Charge	0.41013
NON-PLAN HOSPITAL BENEFITS		0.41014
	50% of the Eligible Charge	0.41014a
	80% of the Plan Hospital Benefit Payment Level	0.41014b
PHYSICIAN BENEFITS Benefit Payment Level	% of the U&C Fee*	0.4102
OTHER COVERED SERVICES BENEFITS		0.4103a
PHYSICIAN BENEFITS AND OTHER COVERED SERVICES BENEFITS		0.4103b
OUTPATIENT HOSPITAL BENEFITS, PHYSICIAN BENEFITS AND OTHER COVERED SERVICES BENEFITS		0.4103c

Deductible per benefit period	$ per individual	0.41031
Family Deductible	individual deductibles	0.410311a
Family Deductible	$ per benefit period	0.410311b
Benefit Payment Level	% of the U&C Fee*	0.41032
Private Duty Nursing Service Benefit Maximum	$ per month	0.41033
Physical Therapy Benefit Maximum	$ per benefit period	0.41034
Occupational Therapy Benefit Maximum	$ per benefit period	0.41035
Speech Therapy Benefit Maximum	$ per benefit period	0.41036
Additional Speech Therapy Benefits for Treatment of Pervasive Developmental Disorders	visits per benefit period	**New**
SPECIAL PAYMENT PROVISIONS		0.4104
Lifetime Maximum for all Benefits	$	0.41041
Out-of-Pocket Expense Limit **(does not apply to all services)**	$ per benefit period	0.41044
Family Out-of-Pocket Expense Limit	individual out-of-pocket expense limits	0.410441a
Family Out-of-Pocket Expense Limit	$ per benefit period	0.410441b
Payment Level for Outpatient Treatment of Mental Illness Other Than Serious Mental Illness and Outpatient Substance Abuse Rehabilitation Treatment	% of the Eligible Charge or U&C Fee*	0.41045a
Payment Level for Outpatient Treatment of Mental Illness Other Than Serious Mental Illness and Outpatient Substance Abuse Rehabilitation Treatment	% of the Eligible Charge or U&C Fee* for the 1st visits then 50% of the Eligible Charge or U&C Fee*	0.41045b

Outpatient Treatment of Mental Illness Other Than Serious Mental Illness and Outpatient Substance Abuse Rehabilitation Treatment benefit maximum	$ per benefit period	0.41046a
Outpatient Treatment of Serious Mental Illness benefit period maximum	visits	code
Outpatient Treatment of Mental Illness Other Than Serious Mental Illness and Outpatient Substance Abuse Rehabilitation Treatment Benefit Period Maximum	visits	0.41046b
Outpatient Treatment of Mental Illness Other Than Serious Mental Illness Benefit Period Maximum	visits	0.41046c
Outpatient Substance Abuse Rehabilitation Treatment Benefit Period Maximum	visits	0.41046c
Combined Lifetime Maximum Outpatient Treatment of Mental Illness Other Than Serious Mental Illness and Substance Abuse Rehabilitation Treatment	visits	0.410451
Inpatient Treatment of Serious Mental Illness		0.41047
— Plan Hospital Payment Level	% of the Eligible Charge	code
— Physician Payment Level	% of the U&C Fee*	code
Inpatient Treatment of Mental Illness Other Than Serious Mental Illness and Inpatient Substance Abuse Rehabilitation Treatment		0.41047
— Plan Hospital Payment Level	% of the Eligible Charge for the 1st days, then 50% of the Eligible Charge	0.41047a
— Plan Hospital Payment Level	% of the Eligible Charge	0.41047b
— Physician Payment Level	% of the U&C Fee*	0.41048
Inpatient Treatment of Serious Mental Illness Benefit Period Maximum	days	code
Inpatient Substance Abuse Rehabilitation Treatment	days	

and Inpatient Treatment of Mental Illness Other Than Serious Mental Illness benefit period maximum		0.41049a
Inpatient Treatment of Mental Illness Other Than Serious Mental Illness Treatment benefit period maximum	days	0.41049b
Inpatient Substance Abuse Rehabilitation Treatment Benefit Period Maximum	days	0.41049b
Inpatient Substance Abuse Rehabilitation Treatment and Inpatient Treatment of Mental Illness Other Than Serious Mental Illness benefit period maximum	$	0.41049c
Combined Lifetime Maximum Inpatient and Outpatient Mental Illness Other Than Serious Mental Illness and Substance Abuse Rehabilitation Treatment	$	0.41050a
Combined Lifetime Maximum Inpatient Treatment of Mental Illness Other Than Serious Mental Illness and Substance Abuse Rehabilitation Treatment	days	0.41050b
INPATIENT PLAN HOSPITAL BENEFITS		0.41
Number of Hospital Days		0.411
Number of Hospital Days for Serious Mental Illness		0.411SMI
Deductible	$ per admission	0.412
Room & Board Payment		0.413a
— Semi-Private	% of the Eligible Charge	0.4131
— Private	% of CSP†	0.4132
Ancillary Services Payment	% of the Eligible Charge	0.4133
Benefit Payment Level	% of the Eligible Charge up to $ per admission, then 80%	0.413b

When you receive Inpatient Hospital services in your Employer Hospital, benefits will be provided at 100% of the Eligible Charge		**0.417**
INPATIENT NON-PLAN HOSPITAL BENEFITS		0.414
	50% of the Eligible Charge	0.414a
	80% of the Plan Hospital Benefit Payment Level	0.414b
OUTPATIENT HOSPITAL BENEFITS		
Plan Benefit Payment Level	% of the Eligible Charge	0.415
Non-Plan Benefit Payment Level	50% of the Eligible Charge	0.4151a
Non-Plan Benefit Payment Level	80% of the Plan Benefit Payment Level	0.4151b
AMBULANCE BENEFITS		
Benefit Payment Level	$, then 80% of the Eligible Charge per trip	0.416
PHYSICIAN BENEFITS		0.42
Surgery Benefit Payment Level	% of the U&C Fee*	0.421
Inpatient Care Medical Visits		0.422
OUTPATIENT DIAGNOSTIC BENEFITS		0.43
Plan Hospital Benefit Payment Level	% of the Eligible Charge $ per benefit period	0.431
Non-Plan Hospital Benefit Payment Level	50% of the Eligible Charge	0.4311a
Non-Plan Hospital Benefit Payment Level	80% of the Plan Benefit Payment Level	0.4311b
Physician Benefit Payment Level	% of the U&C Fee* $ per benefit period	0.432
SUPPLEMENTAL ACCIDENT CARE		

Benefit Payment Level	$ maximum per accident	0.44
MAJOR MEDICAL BENEFITS		Base Plus/CMM 0.46
Lifetime Maximum for all Benefits	$	0.461
Additional Human Organ Transplants Separate Lifetime Maximum	$1,000,000	0.483
Inpatient Hospital Deductible	$ per admission	0.4631
Individual Deductible	$ per benefit period	0.463 **Revised**
Family Deductible	individual deductibles $ per benefit period	0.464
Private Duty Nursing Service Benefit Maximum	$ per monthbenefit period	0.469 0.469a 0.469b
Physical Therapy Benefit Maximum	$ per benefit period	0.433
Occupational Therapy Benefit Maximum	$ per benefit period	0.434
Speech Therapy Benefit Maximum	$ per benefit period	0.435
Physical, Occupational, and Speech Therapies Combined Benefit Maximum	[[5–365] visits][$[1,000–60,000]] per benefit period	**New 9/09**
Additional Speech Therapy Benefits for Treatment of Pervasive Developmental Disorders	20 visits per benefit period	**New**
Additional Speech Therapy Benefits for Treatment of Pervasive Developmental Disorders	visits per benefit period	**New**
Chiropractic and Osteopathic Manipulation Benefit Maximum	$ per benefit period	0.436 **Revised**
Temporomandibular Joint Dysfunction and Related Disorders Lifetime Maximum	$	0.437a
Temporomandibular Joint Dysfunction and Related Disorders Benefit Maximum	$500 per benefit period	0.437b

Well Child Care Benefit Maximum	$ per benefit period	0.4611a
Wellness Care Benefit Maximum	$ per benefit period	0.4611b
When you receive Inpatient Hospital services in your Employer Hospital, benefits will be provided at 100% of the Eligible Charge		**0.470**
Benefit Payment Level	% of the Eligible Charge or U&C Fee*	0.465
— Non-Plan Hospital Payment Level	50% of the Eligible Charge	0.48111a
— Non-Plan Hospital Payment Level	80% of the Plan Hospital Benefit Payment Level	0.48111b
Individual Out-of-Pocket Expense Limit **(does not apply to all services)**	$ per benefit period	0.466 **Revised**
Family Out-of-Pocket Expense Limit	individual out-of-pocket expense limits$ per benefit period	0.466a **Revised**
Emergency Care Payment	% of the Eligible Charge or U&C Fee*, no deductible	0.467a
Emergency Room	$ Copayment	0.4671
Benefit Payment for Accident Care	100% of the Eligible Charge or U&C Fee* up to $ per accident then 80% of the Eligible Charge or U&C Fee*	
Benefit Payment for Emergency Medical Care	% of the Eligible Charge or U&C Fee*	0.467b
Benefit Payment for Outpatient Surgery	% of the Eligible Charge or U&C Fee*, no deductible	0.441 4411
Benefit Payment for Outpatient Diagnostic Services	% of the Eligible Charge or U&C Fee*, no deductible	0.442 4421
Payment Level for Outpatient Treatment of Serious Mental Illness	% of the Eligible Charge or U&C Fee*	code

Payment Level for Outpatient Treatment of Mental Illness Other Than Serious Mental Illness and Outpatient Substance Abuse Rehabilitation Treatment	% of the Eligible Charge or U&C Fee*	0.468a
Payment Level for Outpatient Treatment of Mental Illness Other Than Serious Mental Illness and Outpatient Substance Abuse Rehabilitation Treatment	% of the Eligible Charge or U&C Fee* for the 1st visits then 50% of the Eligible Charge or U&C Fee*	0.468b
Outpatient Treatment of Mental Illness Other Than Serious Mental Illness and Outpatient Substance Abuse Rehabilitation Treatment benefit maximum	$ per benefit period	0.4681a
Outpatient Treatment of Serious Mental Illness benefit period maximum	visits	0.4681d
Outpatient Treatment of Mental Illness Other Than Serious Mental Illness and Outpatient Substance Abuse Rehabilitation Treatment Benefit Period Maximum	visits	0.4681b
Outpatient Treatment of Mental Illness Other Than Serious Mental Illness Benefit Period Maximum	visits	0.4681c
Outpatient Substance Abuse Rehabilitation Treatment Benefit Period Maximum	visits	0.4681c
Combined Lifetime Maximum Outpatient Treatment of Mental Illness Other Than Serious Mental Illness and Substance Abuse Rehabilitation Treatment	visits	0.4682
Inpatient Mental Illness Other Than Serious Mental Illness and Inpatient Substance Abuse Rehabilitation Treatment		0.481
— Plan Hospital Payment Level	% of the Eligible Charge for the 1st days, then 50% of the Eligible Charge	0.4811a
— Plan Hospital Payment Level	% of the Eligible Charge	0.4811b

— Physician Payment Level	% of the U&C Fee*	0.4812	
Inpatient Serious Mental Illness Treatment Benefit Period Maximum	days	0.4813d	**Revised**
Inpatient Substance Abuse Rehabilitation Treatment and Inpatient Mental Illness Treatment Other Than Serious Mental Illness Benefit Period Maximum	days	0.4813a	**Revised**
Inpatient Mental Illness Treatment Other Than Serious Mental Illness Benefit Period Maximum	days	0.4813b	**Revised**
Inpatient Substance Abuse Rehabilitation Treatment Benefit Period Maximum	days	0.4813b	
Inpatient Substance Abuse Rehabilitation Treatment Benefit Period Maximum	$	0.4813c	**Revised**
Combined Lifetime Maximum Substance Abuse Rehabilitation Treatment	$	0.482a	**Revised**
Combined Lifetime Maximum Inpatient Treatment of Mental Illness Other Than Serious Mental Illness and Substance Abuse Rehabilitation Treatment	days	0.482b	

		PPO (Hospital Only)
Lifetime Maximum for all Benefits	$	0.4911a
Lifetime Maximum for all Benefits		
— Participating Hospital	$	0.4911b
— Non-Participating and Non-Plan Hospital	$	
Individual Deductible	$ per benefit period	0.4912a
Individual Deductible		
— Participating Provider Highlights Insert	$ per benefit periodNoneRefer to Benefit	
— Non-Participating and Non-Plan Provider lights Insert	$ per benefit periodRefer to Benefit High-	0.4912b
Family Deductible	individual deductibles $ per benefit period	0.4913
Individual Out-of-Pocket Expense Limit **(does not apply to all services)**	$ per benefit period	0.4914a
Individual Out-of-Pocket Expense Limit **(does not apply to all services)**		
— Participating Hospital lights Insert	$ per benefit periodRefer to Benefit High-	
— Non-Participating Hospital lights Insert	$ per benefit periodRefer to Benefit High-	
— Non-Plan Hospital	No limit	0.4914b
Family Out-of-Pocket Expense Limit	individual out-of-pocket expense limits	0.4915a
Family Out-of-Pocket Expense Limit	$ per benefit period	0.4915b
Family Out-of-Pocket Expense Limit		
— Participating Hospital	$ per benefit period	
— Non-Participating Hospital	$ per benefit period	
— Non-Plan Hospital	No limit	0.4915c
Private Duty Nursing Service Benefit Maximum	$ per monthbenefit period	0.4916 0.4916a 0.4916b
Physical Therapy Benefit Maximum	$ per benefit period	0.4943

Occupational Therapy Benefit Maximum	$ per benefit period	0.4944	
Speech Therapy Benefit Maximum	$ per benefit period	0.4945	
Additional Speech Therapy Benefits for Treatment of Pervasive Developmental Disorders	20 visits per benefit period		
Physical, Occupational, and Speech Therapies Combined Benefit Maximum	[[5–365] visits][$[1,000–60,000]] per benefit period	**New 9/09**	
Additional Speech Therapy Benefits for Treatment of Pervasive Developmental Disorders	20 visits per benefit period		
Chiropractic and Osteopathic Manipulation Benefit Maximum	$ per benefit period	0.4946	**Revised**
Temporomandibular Joint Dysfunction and Related Disorders Lifetime Maximum	$	0.4947a	
Temporomandibular Joint Dysfunction and Related Disorders Benefit Maximum	$500 per benefit period	0.4947b	
Well Child Care Benefit Maximum	$ per benefit period	0.4941a	
Wellness Care Benefit Maximum	$ per benefit period	0.4941b	
Additional Human Organ Transplants Separate Lifetime Maximum	$	0.4917	
Payment Level for Accident Care	100% of the Eligible Charge or U&C Fee* up to $ per accident then paid the same as any other condition	0.4948	
Payment Level for Outpatient Treatment of Mental Illness Other Than Serious Mental Illness and Outpatient Substance Abuse Rehabilitation Treatment	% of the Eligible Charge or U&C Fee*	0.4918a	

Payment Level for Outpatient Treatment of Mental Illness Other Than Serious Mental Illness and Outpatient Substance Abuse Rehabilitation Treatment	% of the Eligible Charge or U&C Fee* for the 1st visits then 50% of the Eligible Charge or U&C Fee*	0.4918b	
Outpatient Substance Abuse Rehabilitation Treatment Benefit Maximum	$ per benefit period	0.49181	**Revised**
Outpatient Treatment of Serious Mental Illness Benefit Period Maximum	visits	0.491821	
Outpatient Treatment of Mental Illness Other Than Serious Mental Illness and Outpatient Substance Abuse Rehabilitation Treatment Benefit Period Maximum	visits	0.49182	
Outpatient Treatment of Mental Illness Other Than Serious Mental Illness Benefit Period Maximum	visits	0.49183	
Outpatient Substance Abuse Rehabilitation Treatment Benefit Period Maximum	visits	0.49183	
Outpatient Treatment of Mental Illness Other Than Serious Mental Illness Lifetime Maximum	visits	**New**	
Outpatient Substance Abuse Rehabilitation Treatment Lifetime Maximum	visits	**New**	
Combined Lifetime Maximum Outpatient Treatment of Mental Illness Other Than Serious Mental Illness and Substance Abuse Rehabilitation Treatment	visits	0.49203	
Payment Level for Inpatient Substance Abuse Rehabilitation Treatment and Inpatient Treatment of Mental Illness Other Than Serious Mental Illness			
— Participating Hospital	% of the Eligible Charge for the 1st days, then 50% of the Eligible Charge	0.49191a	
— Participating Hospital	% of the Eligible Charge	0.49191b	
— Non-Participating Hospital	% of the Eligible Charge for the 1st days then 50% of the Eligible Charge	0.49192a	

— Non-Participating Hospital	50% of the Eligible Charge	0.49192b	
— Non-Plan Hospital	50% of the Eligible Charge	0.49195a	
— Non-Plan Hospital	100% of the Non-Participating Hospital Benefit Payment Level	0.49195b	
— Physician Benefits	% of the U&C Fee*	0.49193	
Inpatient Treatment of Serious Mental Illness Benefit Period Maximum	days	0.49194d	
Inpatient Substance Abuse Rehabilitation Treatment and Inpatient Treatment of Mental Illness Other Than Serious Mental Illness Benefit Period Maximum	days	0.49194a	
Inpatient Treatment of Mental Illness Other Than Serious Mental Illness Benefit Period Maximum	days	0.49194b	
Inpatient Substance Abuse Rehabilitation Treatment Benefit Period Maximum	days	0.49194b	
Inpatient Substance Abuse Rehabilitation Treatment and Inpatient Treatment of Mental Illness Other Than Serious Mental Illness Benefit Period Maximum	$	0.49194c	
Inpatient Treatment of Mental Illness Other Than Serious Mental Illness Lifetime Maximum	days	**New**	
Inpatient Substance Abuse Rehabilitation Treatment Lifetime Maximum	days	**New**	
Inpatient Substance Abuse Rehabilitation Treatment Lifetime Maximum	$	**New**	
Combined Lifetime Maximum Inpatient and Outpatient Substance Abuse Rehabilitation Treatment	$	0.49201	**Revised**
Combined Lifetime Maximum Inpatient Treatment of Mental Illness Other Than Serious Mental Illness and Substance Abuse Rehabilitation Treatment	days	0.49202	

HOSPITAL BENEFITS

Payment level for Covered Services in a **Participating Hospital:**		**0.4922**	
— Inpatient Hospital deductible	$ per admission	0.49223	
— Inpatient Covered Services	% of the Eligible Charge, no deductible	0.49221	**Revised**
— Preadmission Testing	% of the Eligible Charge, no deductible	**New**	
— Plan Coordinated Home Care Program	% of the Eligible Charge, no deductible	**New**	
— Outpatient Covered Services	% of the Eligible Charge, no deductible	0.49222	**Revised**
— Outpatient Surgery	% of the Eligible Charge, no deductible	0.49251	0.492511
— Outpatient Diagnostic Services	% of the Eligible Charge, no deductible	0.49252	0.492521
Payment level for Covered Services in a **Non-Participating Hospital:**		**0.4923**	
— Inpatient Hospital deductible	$ per admission	0.49121	
— Inpatient Covered Services	% of the Eligible Charge, no deductible	0.49231	**Revised**
— Preadmission Testing	% of the Eligible Charge, no deductible	**New**	
— Plan Coordinated Home Care Program	% of the Eligible Charge, no deductible	**New**	
— Outpatient Covered Services	% of the Eligible Charge, no deductible	0.49232	**Revised**
— Outpatient Surgery	% of the Eligible Charge, no deductible	0.49251	0.492511
— Outpatient Diagnostic Services	% of the Eligible Charge, no deductible	0.49252	0.492521
Non-Plan Hospital	50% of the Eligible Charge	0.49261a	
Non-Plan Hospital	100% of the Non-Participating Hospital Benefit Payment Level	0.49261b	
Payment level for Emergency Accident Care or Emergency Medical Care		0.4924a	
Payment level for Emergency Medical Care		0.4924b	
— Participating Hospital	% of the Eligible Charge, no deductible	0.49241	0.492411

— Non-Participating Hospital	% of the Eligible Charge, no deductible	0.49242	0.492411	**Revised**
— Emergency Room sert	$ CopaymentRefer to Benefit Highlights In-	0.49243		
	(waived if admitted to the Hospital as an Inpatient immediately following emergency treatment)			
PHYSICIAN BENEFITS				
Payment level for Surgical/ Medical Covered Services	% of the U&C Fee*, no deductible	0.4930	**Revised**	
Physician office Copayment	$ per visit	0.49301		
Payment level for Well Child Care	% of the U&C Fee*, no deductible	0.4934	0.49341	
Payment level for Emergency Accident Care or Emergency Medical Care when rendered by a Physician	% of the U&C Fee*, no deductible	0.49311 0.4931a		
Payment level for Emergency Medical Care	% of the U&C Fee*, no deductible	0.4931b	0.49311	
Payment level for Outpatient Surgery	% of the U&C Fee*, no deductible	0.4932	0.49321	
Payment level for Outpatient Diagnostic Service	% of the U&C Fee*, no deductible	0.4935	0.49351	
Payment level for Additional Surgical Opinion	100% of the U&C Fee*, no deductible	0.4933		
OTHER COVERED SERVICES				
Payment level	% of the Eligible Charge or U&C Fee*, no deductible	0.4940		
Payment level for Wellness Care		0.4936		
— Participating Hospital	% of the Eligible Charge, no deductible	0.4936	0.49361	
— Non–Participating Hospital	% of the Eligible Charge, no deductible	0.4936	0.49361	
— Physician	% of the U&C Fee*, no deductible	0.4936	0.49361	
— Physician office Copayment	$ per visit	0.49362		

		PPO+ (Hospital & Physician)
Lifetime Maximum for all Benefits	$Unlimited	0.5111a
Lifetime Maximum for all Benefits		
— Participating Provider	Unlimited	
— Non-Participating and Non-Plan Provider	$	0.5111b
Individual Deductible**	$ per benefit periodRefer to Benefit High-	
lights Insert		0.5112a
Individual Deductible**		
— Community Provider Highlights Insert	$ per benefit periodNoneRefer to Benefit	0.5112CPO
— Participating Provider Highlights Insert	$ per benefit periodNoneRefer to Benefit	
— Non-Participating and Non-Plan Provider	$ per benefit periodRefer to Benefit High-	
lights Insert		0.5112b
Individual Coverage Deductible**	$ per benefit periodRefer to Benefit High-	
lights Insert		0.5112c
Individual Coverage Deductible**		
— Participating Provider lights Insert	$ per benefit periodRefer to Benefit High-	
— Non-Participating and Non-Plan Provider	$ per benefit periodRefer to Benefit High-	
lights Insert		0.5112d
Family Deductible	individual deductibles$ per benefit perio-	
dRefer to Benefit Highlights Insert		0.5113a
Family Deductible		
— Participating Provider Highlights Insert	$ per benefit periodNoneRefer to Benefit	
— Non-Participating and Non-Plan Provider	$ per benefit periodRefer to Benefit High-	
lights Insert		0.5113b
Family Coverage Deductible**	$ per benefit periodRefer to Benefit High-	
lights Insert		0.5113c
Family Coverage Deductible**		
— Participating Provider lights Insert	$ per benefit periodRefer to Benefit High-	
— Non-Participating and Non-Plan Provider	$ per benefit periodRefer to Benefit High-	
lights Insert		0.5113d

Individual Out-of-Pocket Expense Limit **(does not apply to all services)**	$ per benefit periodRefer to Benefit Highlights Insert	**Revised** 0.5114
— Community Provider	$ per benefit periodRefer to Benefit Highlights Insert	0.5114CPO 0.5114CPOa 0.5114CPOb
— Participating Provider	$ per benefit periodNoneRefer to Benefit Highlights Insert	
— Non-Participating Provider	$ per benefit periodRefer to Benefit Highlights Insert	0.5114sD 0.5114sG
— Non-Plan Provider	No limit	0.5114s
Individual Coverage Out-of-Pocket Expense Limit**	$ per benefit periodRefer to Benefit Highlights Insert	0.5153
Individual Coverage Out-of-Pocket Expense Limit**		
— Participating Provider	$ per benefit periodRefer to Benefit Highlights Insert	
— Non-Participating Provider	$ per benefit periodRefer to Benefit Highlights Insert	
— Non-Plan Provider	No limit	0.5154
Family Out-of-Pocket Expense Limit	individual out-of-pocket expense limits$ per benefit periodRefer to Benefit Highlights Insert	0.5115a 0.5115a1 0.5115a2 0.511a3 **Revised**
Family Out-of-Pocket Expense Limit		
— Participating Provider	$ per benefit periodNoneRefer to Benefit Highlights Insert	
— Non-Participating Provider	$ per benefit periodRefer to Benefit Highlights Insert	0.5115bD 0.5115bG
— Non-Plan Provider	No limit	0.5115b
Family Coverage Out-of-Pocket Expense Limit**	$per benefit periodRefer to Benefit Highlights Insert	0.5115c
Family Coverage Out-of-Pocket Expense Limit**		
— Participating Provider	$ per benefit periodRefer to Benefit Highlights Insert	
— Non-Participating Provider	$ per benefit periodRefer to Benefit Highlights Insert	
— Non-Plan Provider	No limit	0.5115d
Private Duty Nursing Service		0.5148

Benefit Maximum	$ days per month	0.5148a
Benefit Maximum	$ days per benefit period	0.5148b
Skilled Nursing Facility Care		22.64c1
Coordinated Home Care		22.64c2
Combined Benefit Maximum	$ per benefit period	0.5148e
Well Child Care (under age)		
Benefit Maximum	$ per benefit period applies to Non-Participating Provider	0.5143a
Wellness Care (age & over)		
Benefit Maximum	$ per benefit period applies to Non-Participating Provider	0.5143b
Chiropractic and Osteopathic Manipulation Benefit Maximum	$ visits per benefit period	0.5144
Physical, Occupational, and Speech Therapies Combined Benefit Maximum	[[5–365] visits][$[1,000–60,000]] per benefit period	**New 9/09**
Additional Speech Therapy Benefits for Treatment of Pervasive Developmental Disorders	20 visits per benefit period	0.5147a
Physical Therapy Services Benefit Maximum	$ visits per benefit period	0.5145
Occupational Therapy Benefit Maximum	$ visits per benefit period	0.5146
Speech Therapy Benefit Maximum	$ visits per benefit period	0.5147
Additional Speech Therapy Benefits for Treatment of Pervasive Developmental Disorders	visits per benefit period	0.5147a
Temporomandibular Joint Dysfunction and Related Disorders Lifetime Maximum	$	0.5119a
Temporomandibular Joint Dysfunction and Related Disorders Benefit Maximum	$500 per benefit period	0.5119b
Outpatient Substance Abuse Rehabilitation Treatment Benefit Period Maximum	$	0.5116a
Outpatient Treatment of Serious Mental Illness Benefit Period Maximum	visits	0.5116d

Outpatient Treatment of Mental Illness Other Than Serious Mental Illness and Outpatient Substance Abuse Rehabilitation Treatment Benefit Period Maximum	visits	0.5116b
Outpatient Treatment of Mental Illness Other Than Serious Mental Illness Benefit Period Maximum	visits	0.5116c
Outpatient Substance Abuse Rehabilitation Treatment Benefit Period Maximum	visits	0.5116c1
Combined Lifetime Maximum Outpatient Treatment of Mental Illness Other Than Serious Mental Illness and Substance Abuse Rehabilitation Treatment	visits	0.5150
Lifetime Maximum Outpatient Treatment of Mental Illness Other Than Serious Mental Illness	visits	0.5150a
Lifetime Maximum Outpatient Substance Abuse Rehabilitation Treatment	visits	0.5150b
Lifetime Maximum Outpatient Substance Abuse Rehabilitation Treatment	$	0.5150c
Inpatient Treatment of Serious Mental Illness Benefit Period Maximum	days	0.5117d
Inpatient Substance Abuse Rehabilitation Treatment and Inpatient Treatment of Mental Illness Other Than Serious Mental Illness benefit period maximum	days	0.5117a
Inpatient Treatment of Mental Illness Other Than Serious Mental Illness benefit period maximum	days	0.5117b
Inpatient Substance Abuse Rehabilitation Treatment Benefit Period Maximum	days	0.5117b1
Inpatient Substance Abuse Rehabilitation Treatment Benefit Period Maximum	$	0.5117c

Combined Lifetime Maximum Inpatient Treatment of Mental Illness Other Than Serious Mental Illness and Substance Abuse Rehabilitation Treatment	days	0.5118a
Lifetime Maximum Inpatient Treatment of Mental Illness Other Than Serious Mental Illness	days	0.5118c
Lifetime Maximum Inpatient Substance Abuse Rehabilitation Treatment	days	0.5118e
Lifetime Maximum Inpatient Substance Abuse Rehabilitation Treatment	$	0.5118d
Combined Lifetime Maximum Inpatient and Outpatient Substance Abuse Rehabilitation Treatment	$	0.5118b
Payment Level for Accident Care	100% of the Eligible Charge or Maximum Allowance up to $ per accident then paid the same as any other condition	0.5149
HOSPITAL BENEFITS		0.5121
Payment level for Covered Services from a **Community Provider:**		0.5121
— Inpatient Covered Services	% of the Eligible ChargeRefer to Benefit Highlights Insert	0.5121CPO
— Inpatient Substance Abuse Rehabilitation Treatment and Inpatient Treatment of Mental Illness Other Than Serious Mental Illness	Refer to Benefit Highlights Insert% of the Eligible Charge for the 1st days, then 50% of the Eligible Charge	0.51221aCPO
— Inpatient Substance Abuse Rehabilitation Treatment and Inpatient Treatment of Mental Illness Other Than Serious Mental Illness	% of the Eligible ChargeRefer to Benefit Highlights Insert	0.51221bCPO
— Outpatient Covered Services	% of the Eligible ChargeRefer to Benefit Highlights Insert	0.5123CPO

— Outpatient Diagnostic Services	% of the Eligible Charge, no deductible	0.5123CPO
— Wellness Care	% of the Eligible Charge, no deductibleRefer to Benefit Highlights Insert	
— Outpatient Treatment of Mental Illness Other Than Serious Mental Illness and Outpatient Substance Abuse Rehabilitation Treatment	% of the Eligible ChargeRefer to Benefit Highlights Insert	CPO
Payment level for Covered Services from a **Participating Provider:**		0.5122
— Inpatient Deductible	$ per admissionRefer to Benefit Highlights Insert	0.51222
— Inpatient Covered Services	% of the Eligible ChargeRefer to Benefit Highlights Insert, no deductible	0.5122
— Preadmission Testing	% of the Eligible Charge, no deductible	0.51223
— Coordinated Home Care Program	% of the Eligible Charge, no deductible	0.51224
— Inpatient Substance Abuse Rehabilitation Treatment and Inpatient Treatment of Mental Illness Other Than Serious Mental Illness	Refer to Benefit Highlights Insert% of the Eligible Charge for the 1st days, then 50% of the Eligible Charge	0.51221a
— Inpatient Substance Abuse Rehabilitation Treatment and Inpatient Treatment of Mental Illness Other Than Serious Mental Illness	% of the Eligible ChargeRefer to Benefit Highlights Insert	0.51221b
— Outpatient Covered Services	% of the Eligible ChargeRefer to Benefit Highlights Insert, no deductible	0.5123
— Outpatient Surgery	% of the Eligible ChargeRefer to Benefit Highlights Insert, no deductible	0.5131 0.51311
— Outpatient Diagnostic Services	% of the Eligible ChargeRefer to Benefit Highlights Insert, no deductible	0.5130 0.51301

— Urgent Care	$ Copayment, then % of the Eligible Charge, no deductible	0.51232	0.512321		
— Wellness Care	% of the Eligible ChargeRefer to Benefit Highlights Insert, no deductible	0.51233	0.512331	0.512332	0.512333
— Outpatient Treatment of Mental Illness Other Than Serious Mental Illness and Outpatient Substance Abuse Rehabilitation Treatment	% of the Eligible ChargeRefer to Benefit Highlights Insert	0.51231a			
— Outpatient Treatment of Mental Illness Other Than Serious Mental Illness and Outpatient Substance Abuse Rehabilitation Treatment	Refer to Benefit Highlights Insert % of the Eligible Charge for the 1st visits, then 50% of the Eligible Charge	0.51231b			
Payment level for Covered Services from a **Non-Participating Provider:**		0.5124			
— Inpatient Deductible	$ per admissionRefer to Benefit Highlights Insert	0.5125			
— Inpatient Covered Services	% of the Eligible ChargeRefer to Benefit Highlights Insert	0.5126			
— Preadmission Testing	% of the Eligible Charge, no deductible	0.51262			
— Coordinated Home Care Program	% of the Eligible Charge, no deductible	0.51263			
— Inpatient Substance Abuse Rehabilitation Treatment and Inpatient Treatment of Mental Illness Other Than Serious Mental Illness	Refer to Benefit Highlights Insert% of the Eligible Charge for the 1st days, then 50% of the Eligible Charge	0.51261a			
— Inpatient Substance Abuse Rehabilitation Treatment and Inpatient Treatment of Mental Illness Other Than Serious Mental Illness	% of the Eligible ChargeRefer to Benefit Highlights Insert	0.51261b			
— Outpatient Covered Services	% of the Eligible ChargeRefer to Benefit Highlights Insert, no deductible	0.5127			

— Outpatient Surgery Highlights Insert,	% of the Eligible ChargeRefer to Benefit no deductible	0.5131	0.51501		
— Outpatient Diagnostic Highlights Insert, Services	% of the Eligible ChargeRefer to Benefit no deductible	0.5130	0.51512		
— Urgent Care	$ Copayment, then % of the Eligible Charge, no deductible	0.51272	0.512721		
— Wellness Care Highlights Insert,	% of the Eligible ChargeRefer to Benefit no deductible	0.51233	0.512332	0.512333	0.512334
— Outpatient Treatment of Highlights Insert Mental Illness Other Than Serious Mental Illness and Outpatient Substance Abuse Rehabilitation Treatment	% of the Eligible ChargeRefer to Benefit	0.51271a			
— Outpatient Treatment of gible Charge Mental Illness Other Than Serious Mental Illness and Outpatient Substance Abuse Rehabilitation Treatment	Refer to Benefit Highlights Insert% of the Eli- for the 1st visits, then 50% of the Eligible Charge	0.51271b			
Payment level for Covered Services from a **Non-Plan Provider**	50% of the Eligible Charge	0.5139a			
Payment level for Covered Services from a **Non-Plan Provider**	100% of the Non-Participating Hospital Benefit Payment Level	0.5139b			
Hospital Emergency Care					
— Payment level for Highlights Insert, Emergency Accident Care from either a Community, Participating, Non-Participating or Non-Plan Provider	% of the Eligible ChargeRefer to Benefit no deductible	0.5128a	0.51282		

— Payment level for Highlights Insert, Emergency Medical Care from either a Community, Participating, Non-Participating or Non-Plan Provider	% of the Eligible ChargeRefer to Benefit no deductible	0.5128b 0.51611
Emergency Room sert	$ CopaymentRefer to Benefit Highlights In- (waived if admitted to the Hospital as an Inpatient immediately following emergency treatment)	0.51281
PHYSICIAN BENEFITS		
Payment level for Surgical/ Medical Covered Services		
— **Community Provider** fit Highlights Insert	% of the Maximum AllowanceRefer to Bene-	0.5132CPO
— **Participating Provider** fit Highlights Insert,	% of the Maximum AllowanceRefer to Bene- no deductible	0.5132
— **Non-Participating Provider** fit Highlights Insert,	% of the Maximum AllowanceRefer to Bene- no deductible	0.5133
Payment level for Physician Office Visits		
— Community Provider Benefit Highlights Insert	$ per visit, then % of the Maximum Allowance, no deductibleRefer to	0.51321CPO
— Participating Provider (other than a specialist) Benefit Highlights Insert	$ per visit, then % of the Maximum Allowance, no deductibleRefer to	0.51321a
— Participating Provider Specialist Benefit Highlights Insert	$ per visit, then % of the Maximum Allowance, no deductibleRefer to	0.51321aS
— Non-Participating Provider (other than a specialist) Benefit Highlights Insert	$ per visit, then % of the Maximum Allowance, no deductibleRefer to	0.51321b
— Non-Participating Provider Specialist Benefit Highlights Insert	$ per visit, then % of the Maximum Allowance, no deductibleRefer to	0.51321bS
Payment level for Covered Services received in a Professional Provider's Office		
— Participating Provider (other than a specialist) Benefit Highlights Insert	$ per visit, then % of the Maximum Allowance, no deductibleRefer to	0.51322a

— Participating Provider Specialist	$ per visit, then % of the Maximum Allowance, no deductibleRefer to Benefit Highlights Insert	0.51322aS
— Non-Participating Provider (other than a specialist)	$ per visit, then % of the Maximum Allowance, no deductibleRefer to Benefit Highlights Insert	0.51322b
— Non-Participating Provider Specialist	$ per visit, then % of the Maximum Allowance, no deductibleRefer to Benefit Highlights Insert	0.51322bS
Payment level for Well Child Care		
— Participating Provider	% of the Maximum Allowance (subject to the Physician's office visit Copayment), no deductibleRefer to Benefit Highlights Insert	0.51323a1
— Participating Provider	$ per visit, then % of the Maximum Allowance, no deductibleRefer to Benefit Highlights Insert	0.51323a2
— Non-Participating Provider	% of the Maximum Allowance, (subject to the Physician's office visit Copayment), no deductibleRefer to Benefit Highlights Insert	0.51323b1
— Non-Participating Provider	$ per visit, then % of the Maximum Allowance, no deductibleRefer to Benefit Highlights Insert	0.51323b2
Payment level for Outpatient Diagnostic Service		
— Community Provider	% of the Maximum Allowance, no deductible	CPO
— Participating Provider	% of the Maximum Allowance, no deductible	0.5135 0.51351
— Non-Participating Provider	% of the Maximum Allowance, no deductible	0.5136 0.5136a
Payment level for Outpatient Surgery		
— Community Provider	% of the Maximum Allowance, no deductible	CPO
— Participating Provider	% of the Maximum Allowance, no deductible	0.5151 0.51511
— Non-Participating Provider	% of the Maximum Allowance, no deductible	0.5152 0.51511a

Payment level for Emergency fit Highlights Insert	% of the Maximum Allowance,Refer to Bene-	
Accident Care	no deductible	0.5134a 0.51341
— Physician office Copayment	$ per visitRefer to Benefit Highlights Insert	0.513411a....0.513412
— In Provider's office	$ per visit, then % of the Maximum Allowance, no deductibleRefer to	
Benefit Highlights Insert		
Payment level for Emergency fit Highlights Insert	% of the Maximum Allowance,Refer to Bene-	
Medical Care	no deductible	0.5134b 0.51341a
— Physician office Copayment	$ per visitRefer to Benefit Highlights Insert	0.513411b...0.5134122
— In Provider's office	$ per visit, then % of the Maximum Allowance, no deductibleRefer to	
Benefit Highlights Insert		
Payment level for Wellness Care		
— **Community Provider**	% of the Maximum Allowance, no deductibleRefer to Benefit Highlights In-	
sert		
— In Provider's office	$ per visit, then % of the Maximum Allowance, no deductibleRefer to	
Benefit Highlights Insert		
— Office visits	$ per visit, then % of the Maximum Allowance, no deductibleRefer to	
Benefit Highlights Insert		0.51233CPO2
— **Participating Provider**	% of the Maximum Allowance, no deductibleRefer to Benefit Highlights In-	
sert		0.51233 0.512331 0.512332 0.512333
— In Provider's office	$ per visit, then % of the Maximum Allowance, no deductibleRefer to	
Benefit Highlights Insert		0.51233a1
— Office visits	$ per visit, then % of the Maximum Allowance, no deductibleRefer to	
Benefit Highlights Insert		0.51233a2
— **Non-Participating Provider**	% of the Maximum Allowance, no deductibleRefer to Benefit Highlights In-	
sert		0.51233 0.512332 0.512333 0.512334
— In Provider's office	$ per visit, then % of the Maximum Allowance, no deductibleRefer to	
Benefit Highlights Insert		0.51233b1
— Office visits	$ per visit, then % of the Maximum Allowance, no deductibleRefer to	
Benefit Highlights Insert		0.51233b2

Payment level for Outpatient Treatment of Mental Illness Other Than Serious Mental Illness and Outpatient Substance Abuse Rehabilitation Treatment			
— **Participating Provider**	% of the Maximum AllowanceRefer to Benefit Highlights Insert	0.5141	
— In Provider's office	$ per visit, then % of the Maximum Allowance, no deductibleRefer to Benefit Highlights Insert		
— Office visits	$ per visit, then % of the Maximum Allowance, no deductibleRefer to Benefit Highlights Insert		
— **Non-Participating Provider**	% of the Maximum AllowanceRefer to Benefit Highlights Insert	0.5142	
— In Provider's office	$ per visit, then % of the Maximum Allowance, no deductibleRefer to Benefit Highlights Insert		
— Office visits	$ per visit, then % of the Maximum Allowance, no deductibleRefer to Benefit Highlights Insert		
Additional Surgical Opinion	100% of the Claim Charge, no deductible	0.51324	0.513241
OTHER COVERED SERVICES			
Payment level	% of the Eligible Charge or Maximum AllowanceRefer to Benefit Highlights Insert	0.5137	
Payment level for Outpatient drugs and medicines	% of the Eligible ChargeRefer to Benefit Highlights Insert	0.51371	

		BlueChoice Select
Lifetime Maximum for all Benefits	$Unlimited	0.5411a
Lifetime Maximum for all Benefits		
— In-Network	Unlimited	
— Out-of-Network and Non-Plan Provider	$	0.5411b
Individual Deductible lights Insert	$ per benefit periodRefer to Benefit High-	0.5412a
Individual Deductible		
— In-Network Highlights Insert	$ per benefit periodNoneRefer to Benefit	
— Out-of-Network and Non-Plan Provider lights Insert	$ per benefit periodRefer to Benefit High-	0.5412b
Individual Coverage Deductible** lights Insert	$ per benefit periodRefer to Benefit High-	0.5412c
Individual Coverage Deductible**		
— In-Network lights Insert	$ per benefit periodRefer to Benefit High-	
— Out-of-Network and Non-Plan Provider lights Insert	$ per benefit periodRefer to Benefit High-	0.5412d
Family Deductible efer to Benefit Highlights Insert	individual deductibles$ per benefit period R-	0.5413a
Family Deductible		
— In-Network Highlights Insert	$ per benefit periodNoneRefer to Benefit	
— Out-of-Network and Non-Plan Provider lights Insert	$ per benefit periodRefer to Benefit High-	0.5413b
Family Coverage Deductible** lights Insert	$ per benefit periodRefer to Benefit High-	0.5413c
Family Coverage Deductible**		
— In-Network lights Insert	$ per benefit periodRefer to Benefit High-	
— Out-of-Network and Non-Plan Provider lights Insert	$ per benefit periodRefer to Benefit High-	0.5413d
Individual Out-of-Pocket Expense Limit **(does not apply to all services)**		

— In-Network	$ per benefit periodNoneRefer to Benefit Highlights Insert	
— Out-of-Network	$ per benefit periodRefer to Benefit Highlights Insert	
— Non-Plan Provider	No limit	0.5314
Individual Coverage Out-of-Pocket Expense Limit**	$ per benefit periodRefer to Benefit Highlights Insert	0.5353
Individual Coverage Out-of-Pocket Expense Limit**		
— In-Network	$ per benefit periodRefer to Benefit Highlights Insert	
— Out-of-Network	$ per benefit periodRefer to Benefit Highlights Insert	
— Non-Plan Provider	No limit	0.5354
Family Out-of-Pocket Expense Limit	individual out-of-pocket expense limits	0.5315a
Family Out-of-Pocket Expense Limit		
— In-Network	$ per benefit periodNoneRefer to Benefit Highlights Insert	
— Out-of-Network	$ per benefit periodRefer to Benefit Highlights Insert	
— Non-Plan Provider	No limit	0.5315b
Family Coverage Out-of-Pocket Expense Limit**	$ per benefit periodRefer to Benefit Highlights Insert	0.5315c
Family Coverage Out-of-Pocket Expense Limit**		
— In-Network	$ per benefit periodRefer to Benefit Highlights Insert	
— Out-of-Network	$ per benefit periodRefer to Benefit Highlights Insert	
— Non-Plan Provider	No limit	0.5315d
Private Duty Nursing Service		0.5348
Benefit Maximum	$ per month	0.5348a
Benefit Maximum	$ per benefit period	0.5348b
Skilled Nursing Facility Care		35.64c1
Coordinated Home Care		35.64c2
Combined Benefit Maximum	$ per benefit period	35.64c
Wellness Care		
Benefit Maximum (children under age)	$ per benefit period, applies Out-of-Network	0.5343a

Wellness Care Benefit Maximum (all ages)	$ per benefit period, applies Out-of-Network	0.5343b
Wellness Care Benefit Maximum (children under age) (persons age and over)	 $ per benefit period $ per benefit period (applies Out-of–Network)	0.5343c
Well Child Care Benefit Maximum	$ per benefit period applies Out-of Network	0.5343d
Wellness Care (age & over) Benefit Maximum	$ per benefit period applies Out-of-Network	0.5343e
Chiropractic and Osteopathic Manipulations Benefit Maximum	$ per benefit period	0.5344
Physical Therapy Services Benefit Maximum	$[1,000–60,000]][5–365] visits per benefit period applies Out-of-Network	**Revised** 0.5345
Occupational Therapy Benefit Maximum	$[1,000–60,000]][5–365] visits per benefit period applies Out-of-Network	**Revised** 0.5346
Speech Therapy Benefit Maximum	$[1,000–60,000]][5–365] visits perbenefit pe- riod applies Out-of-Network	**Revised** 0.5347
Physical, Occupational, and Speech Therapies Combined Benefit Maximum	[[5–365] visit][$[1,000–60,000]] per benefit period	**New 9/09**
Additional Speech Therapy Benefits for Treatment of Pervasive Developmental Disorders	20 visits per benefit period applies Out-of-Network	
Additional Speech Therapy Benefits for Treatment of Pervasive Developmental Disorders	visits per benefit period applies Out-of-Network	
Temporomandibular Joint Dysfunction and Related Disorders Lifetime Maximum	$, applies Out-of-Network	0.5319a

Temporomandibular Joint Dysfunction and Related Disorders Benefit Maximum	$500 per benefit period	0.5319b
Outpatient Substance Abuse Rehabilitation Treatment Benefit Period Maximum	$	0.5316a
Outpatient Treatment of Serious Mental Illness Benefit Period Maximum	visits	0.5316d
Outpatient Treatment of Mental Illness Other Than Serious Mental Illness and Outpatient Substance Abuse Rehabilitation Treatment Benefit Period Maximum	visits	0.5316b
Outpatient Treatment of Mental Illness Other Than Serious Mental Illness Benefit Period Maximum	visits	0.5316c
Outpatient Substance Abuse Rehabilitation Treatment Benefit Period Maximum	visits	0.5316c1
Combined Lifetime Maximum Outpatient Treatment of Mental Illness Other Than Serious Mental Illness and Substance Abuse Rehabilitation Treatment	visits	0.5350
Lifetime Maximum Outpatient Treatment of Mental Illness Other Than Serious Mental Illness	visits	0.5350a
Lifetime Maximum Outpatient Substance Abuse Rehabilitation Treatment	visits	0.5350b
Lifetime Maximum Outpatient Substance Abuse Rehabilitation Treatment	$	0.5350c
Inpatient Treatment of Serious Mental Illness Benefit Period Maximum	days	0.5317d
Inpatient Substance Abuse Rehabilitation Treatment and Inpatient Treatment of Mental Illness Other Than Serious Mental Illness benefit period maximum	days	0.5317a

Inpatient Treatment of Mental Illness Other Than Serious Mental Illness benefit period maximum	days	0.5317b
Inpatient Substance Abuse Rehabilitation Treatment Benefit Period Maximum	days	0.5317b1
Inpatient Substance Abuse Rehabilitation Treatment Benefit Period Maximum	$	0.5317c
Combined Lifetime Maximum Inpatient Treatment of Mental Illness Other Than Serious Mental Illness and Substance Abuse Rehabilitation Treatment	days	0.5318a
Lifetime Maximum Inpatient Treatment of Mental Illness Other Than Serious Mental Illness	days	0.5318c
Lifetime Maximum Inpatient Substance Abuse Rehabilitation Treatment	days	0.5318e
Lifetime Maximum Inpatient Substance Abuse Rehabilitation Treatment	$	0.5318d
Combined Lifetime Maximum Inpatient and Outpatient Substance Abuse Rehabilitation Treatment	$	0.5318b
Payment Level for Accident Care	100% of the Eligible Charge or Maximum Allowance up to $ per accident then paid the same as any other condition	0.5349
HOSPITAL BENEFITS		0.5321
Payment level for Covered Services received **In-Network:**		0.5321
— Inpatient Deductible	$ per admission	0.53222
— Inpatient Covered Services	% of the Eligible Charge	0.5322
— Inpatient Substance Abuse Rehabilitation Treatment and Inpatient Treatment of Mental Illness Other Than Serious Mental Illness	% of the Eligible Charge for the 1st days, then 50% of the Eligible Charge	0.53221a

— Inpatient Substance Abuse Rehabilitation Treatment and Inpatient Treatment of Mental Illness Other Than Serious Mental Illness	% of the Eligible Charge	0.53221b
— Outpatient Covered Services	% of the Eligible Charge	0.5323
— Outpatient Surgery	% of the Eligible Charge no deductible	0.5331 0.53311
— Outpatient Diagnostic Services	% of the Eligible Charge no deductible	0.5330 0.53301
— Outpatient Treatment of Mental Illness Other Than Serious Mental Illness and Outpatient Substance Abuse Rehabilitation Treatment	% of the Eligible Charge	0.53231a
— Outpatient Treatment of Mental Illness Other Than Serious Mental Illness and Outpatient Substance Abuse Rehabilitation Treatment	% of the Eligible Charge for the 1st visits, then 50% of the Eligible Charge	0.53231b
Payment level for Covered Services received **Out-of-Network:**		0.5324
— Inpatient Deductible	$ per admission	0.5325
— Inpatient Covered Services	% of the Eligible Charge	0.5326
— Inpatient Substance Abuse Rehabilitation Treatment and Inpatient Treatment of Mental Illness Other Than Serious Mental Illness	% of the Eligible Charge for the 1st days, then 50% of the Eligible Charge	0.53261a
— Inpatient Substance Abuse Rehabilitation Treatment and Inpatient Treatment of Mental Illness Other Than Serious Mental Illness	% of the Eligible Charge	0.53261b
— Outpatient Covered Services	% of the Eligible Charge	0.5327
— Outpatient Surgery	% of the Eligible Charge no deductible	0.5331 0.53501
— Outpatient Diagnostic Services	% of the Eligible Charge no deductible	0.5330 0.53512

— Outpatient Treatment of Mental Illness Other Than Serious Mental Illness and Outpatient Substance Abuse Rehabilitation Treatment	% of the Eligible Charge	0.53271a
— Outpatient Treatment of Mental Illness Other Than Serious Mental Illness and Outpatient Substance Abuse Rehabilitation Treatment	% of the Eligible Charge for the 1st visits, then 50% of the Eligible Charge	0.53271b
Payment level for Covered Services from a **Non-Plan Provider**	50% of the Eligible Charge	0.5339a
Payment level for Covered Services from a **Non-Plan Provider**	100% of the Out-of-Network Hospital Benefit Payment Level	0.5339b
Hospital Emergency Care		
— Payment level for Emergency Accident Care received either In-Network, Out-of-Network or from a Non-Plan Provider	% of the Eligible Charge no deductible	0.5328a 0.53282
— Payment level for Emergency Medical Care received either In-Network, Out-of-Network or from a Non-Plan Provider	% of the Eligible Charge no deductible	0.5328b 0.53611
Emergency Room sert	$ CopaymentRefer to Benefit Highlights In-	
	(waived if admitted to the Hospital as an Inpatient immediately following emergency treatment)	0.53281
PHYSICIAN BENEFITS		
Payment level for Surgical/ Medical Covered Services		
— In-Network	% of the Maximum Allowance	0.5332
— Out-of-Network	% of the Maximum Allowance	0.5333
Professional Provider office Copayment		
— In-Network	$ per visit Refer to Benefit Highlights Insert	0.53321a
— Out-of-Network	$ per visitRefer to Benefit Highlights Insert	0.53321b

Payment level for Emergency Accident Care when rendered by a Physician	% of the Maximum Allowance no deductible	0.5334a	0.53341
Payment level for Emergency Medical Care when rendered by a Physician	% of the Maximum Allowance no deductible	0.5334b	0.53341a
Payment level for Outpatient Diagnostic Service			
— In-Network	% of the Maximum Allowance no deductible	0.5335	0.53351
— Out-of-Network	% of the Maximum Allowance no deductible	0.5336	0.5336a
Payment level for Outpatient Surgery			
— In-Network	% of the Maximum Allowance no deductible	0.5351	0.53511
— Out-of-Network	% of the Maximum Allowance no deductible	0.5352	0.53511a
Payment level for Outpatient Treatment of Mental Illness Other Than Serious Mental Illness and Outpatient Substance Abuse Rehabilitation Treatment			
— In-Network	% of the Maximum Allowance	0.5341	
— Out-of-Network	% of the Maximum Allowance	0.5342	
Additional Surgical Opinion	100% of the Claim Charge, no deductible	0.53322	0.533221
OTHER COVERED SERVICES			
Payment level	% of the Eligible Charge or Maximum Allowance	0.5337	
Payment level for Highlights Insert Outpatient drugs and medicines	% of the Eligible ChargeRefer to Benefit	0.53371	

		BlueChoice
Lifetime Maximum		
— In-Network	Unlimited	
— Out-of-Network	$	0.5211
Individual Annual Deductible		
— In-Network	None	
— Out-of-Network	$	0.5212
Family Annual Deductible		
— In-Network	None	
— Out-of-Network	$	0.5213
Individual Out-of-Pocket Expense Limit (does not apply to all services)		
— In-Network	$ per benefit period	
— Out-of-Network	$ per benefit period	0.5214
Family Out-of-Pocket Expense Limit		
— In-Network	$ per benefit period	
— Out-of-Network	$ per benefit period	0.5215
Private Duty Nursing Service Benefit Maximum	$ per month	0.5216
Physical Therapy Benefit Maximum		
— In-Network	Unlimited	
— Out-of-Network	$ per benefit period	0.5217
Occupational Therapy Benefit Maximum		
— In-Network	Unlimited	
— Out-of-Network	$ per benefit period	0.5218
Speech Therapy Benefit Maximum		
— In-Network	Unlimited	
— Out-of-Network	$ per benefit period	0.5219
Muscle Manipulation Benefit Maximum		
— In-Network	Unlimited	
— Out-of-Network	$ per benefit period	0.5220
Temporomandibular Joint Dysfunction and Related Disorders Lifetime Maximum		
— In-Network	Unlimited	

— Out-of-Network	$	0.5221
Hospital Benefits		
Payment level **In-Network:**		
— Inpatient Copayment	$ per confinement	0.5228
— Inpatient Covered Services	% of the Eligible Charge	0.5229
— Outpatient Covered Services	% of the Eligible Charge	0.5230
Payment level **Out-of-Network:**		
— Inpatient Covered Services	% of the Eligible Charge	0.5231
— Outpatient Covered Services	% of the Eligible Charge	0.5232
Payment level for Covered Services from a **Non-Plan Provider**	50% of the Eligible Charge	
Hospital Emergency Care		
— Payment level for Emergency Accident Care or Emergency Medical Care either In-Network or Out-of-Network	% of the Eligible Charge	0.5233
— Emergency Room Copayment	$ per visit	0.5234
Hospital Outpatient Diagnostic Service and Outpatient Surgery		
— In-Network	% of the Eligible Charge	
— Out-of-Network	% of the Eligible Charge, no deductible	0.5235
Physician Benefits		
Payment level for Surgical/ Medical Covered Services		
— **In-Network**	% of the Maximum Allowance	0.5236
— In-Network office visit	% of the Maximum Allowance	0.5237
— In-Network office Copayment	$ per visit	0.5238
— **Out-of-Network**	% of the Maximum Allowance	0.5239
Payment level for Emergency Accident Care or Emergency Medical Care when rendered by a Professional Provider either In-Network or Out-of-Network	% of the Maximum Allowance	
— Physician office Copayment	$ per visit	0.5240
Consultations (Outpatient)		
— In-Network	% of the Maximum Allowance	0.5241
— In-Network office Copayment	$ per visit	0.5242

— Out-of-Network	% of the Maximum Allowance	0.5243
Other Covered Services		
Payment level **In-Network**	% of the Eligible Charge or Maximum Allowance	
Payment level **Out-of-Network**	% of the Eligible Charge or Maximum Allowance	0.5244
Payment Level for Wellness Care		
— **In-Network**		
— Physician office Copayment	$ per visit	
— Routine physical examinations and routine diagnostic tests	% of the Eligible Charge or Maximum Allowance	
— Immunizations	% of the Eligible Charge or Maximum Allowance	0.5245
— **Out-of-Network**	% of the Eligible Charge or Maximum Allowance	0.5246
— Lifetime Maximum	$	0.5247
Payment level for Treatment of Mental Illness and Substance Abuse Rehabilitation Treatment		
— **In-Network**	% of the Eligible Charge or Maximum Allowance	0.5248
— **Out-of-Network**	% of the Eligible Charge or Maximum Allowance	0.5249
Payment level for Chronic Condition Management		
— **In-Network**	100% of the Maximum Allowance	
— **Out-of-Network**	% of the Maximum Allowance	0.5250
Outpatient Treatment of Serious Mental Illness Benefit Period Maximum		
— age 19 and over	visits	
— age 18 and under	visits	0.52221
Outpatient Treatment of Mental Illness Other Than Serious Mental Illness Benefit Period Maximum		
— age 19 and over	visits	
— age 18 and under	visits	0.5222

Outpatient Substance Abuse Rehabilitation Treatment Benefit Period Maximum			
— age 19 and over	visits		
— age 18 and under	visits	0.5223	
Chronic Condition Management benefit maximum	one visit per month	0.5224	
Inpatient Treatment of Serious Mental Illness Benefit Period Maximum	days	0.52251	
Inpatient Treatment of Mental Illness Other Than Serious Mental Illness Benefit Period Maximum	days	0.5225	
Inpatient Substance Abuse Rehabilitation Treatment Benefit Period Maximum	days	0.5226	
Inpatient and Outpatient Treatment of Mental Illness Other Than Serious Mental Illness and Substance Abuse Rehabilitation Treatment Combined Benefit Period Maximum			
— In-Network and Out-of-Network	$	0.5251	
Combined Lifetime Maximum Inpatient and Outpatient Treatment of Mental Illness Other Than Serious Mental Illness and Substance Abuse Rehabilitation Treatment			
— In-Network and Out-of-Network	$ (Out-of-Network $)	0.5227a	0.52271
Combined Lifetime Maximum Inpatient Treatment of Mental Illness Other Than Serious Mental Illness and Substance Abuse Rehabilitation Treatment			
— In-Network and Out-of-Network	days	0.5227b	
Combined Lifetime Maximum Outpatient Treatment of Mental Illness Other Than Serious Mental Illness and Substance Abuse Rehabilitation Treatment			

— In-Network and Out-of-Network	visits	0.5227c

PRIOR TO RECEIVING COVERED SERVICES FOR THE TREATMENT OF MENTAL ILLNESS, SUBSTANCE ABUSE REHABILITATION TREATMENT AND CHRONIC CONDITION MANAGEMENT, YOU MUST, IN ORDER TO RECEIVE MAXIMUM IN-NETWORK BENEFITS, CALL AND FOLLOW THE RECOMMENDATION OF THE MENTAL HEALTH UNIT AT 1-800-851-7498.

PRESCRIPTION DRUG PROGRAM BENEFITS		0.45
Individual Deductible	$ per benefit period	0.458
Family Deductible	individual deductibles	0.455
Copayment		
— Drugs and diabetic supplies (other than Specialty Drugs)	$ per prescription	0.451
— Specialty Drugs	$ per prescription	0.452a1
Copayment for drugs and supplies (other than Specialty Drugs)		
— Generic drugs and generic diabetic supplies or brand name drugs and brand name diabetic supplies for which there is no generic drug or supply available	$ per prescription	
— Brand name drugs and brand name diabetic supplies	$ per prescription	0.452a
— Self-injectable drugs other than insulin and infertility drugs	$ per prescription	0.454
Copayment for Specialty Drugs	$ per prescription	0.454a
Copayment for drugs and supplies (other than Specialty Drugs)		
— Generic drugs and generic diabetic supplies and diabetic supplies	$ per prescription	
— Formulary brand name drugs and Formulary brand name diabetic supplies	$ per prescription	
— Non-Formulary brand name drugs and non-Formulary brand name diabetic supplies	$ per prescription	0.452b
— Self-injectable drugs other than insulin and infertility drugs	$ per prescription	0.4514
Copayment for Specialty Drugs	$ per prescription	0.4514a
Copayment for drugs and supplies (other than Specialty Drugs)		
— Generic drugs and generic diabetic supplies and diabetic supplies	$ per prescription	

— Brand name drugs and brand name diabetic supplies for which there is no generic drug or supply available	$ per prescription	
— Brand name drugs and brand name diabetic supplies for which there is a generic drug or supply available	$ per prescription	0.452c
Copayment for Specialty Drugs	$ per prescription	0.452c1
Payment level for drugs and supplies (other than Specialty Drugs)		
— Generic drugs and generic diabetic supplies and diabetic supplies	% of the Eligible Charge per prescription	0.452d1
— Generic drugs and generic diabetic supplies and diabetic supplies	$ per prescription	0.452d2
— Formulary brand name drugs and Formulary brand name diabetic supplies and diabetic supplies	% of the Eligible Charge per prescription	
— Non-Formulary brand name drugs and non-Formulary brand name diabetic supplies	% of the Eligible Charge per prescription	0.452d
Payment level for Specialty Drugs	% of the Eligible Charge per prescription	0.452d3
Maximum Coinsurance		0.452d4
— Generic drugs and generic diabetic supplies and diabetic supplies (other than Specialty Drugs)	$ per prescription	0.452d4
— Formulary brand name drugs and Formulary brand name diabetic supplies (other than Specialty Drugs)	$ per prescription	0.452d4
— Non-Formulary brand name drugs and non-Formulary brand name diabetic supplies (other than Specialty Drugs)	$ per prescription	0.452d4
— Specialty Drugs	$ per prescription	0.452d5
Minimum Coinsurance		0.452d5
— Generic drugs and generic diabetic supplies and		

diabetic supplies (other than Specialty Drugs)	$ per prescription	0.452d4
— Formulary brand name drugs and Formulary brand name diabetic supplies (other than Specialty Drugs)	$ per prescription	0.452d4
— Non-Formulary brand name drugs and non-Formulary brand name diabetic supplies (other than Specialty Drugs)	$ per prescription	0.452d4
— Specialty Drugs	$ per prescription	0.452d5
Copayment for drugs and supplies (other than Specialty Drugs)		
— Generic drugs and generic diabetic supplies and diabetic supplies	$ per prescription	
— Formulary brand name drugs and Formulary brand name diabetic supplies	$ per prescription	
— Non-Formulary brand name drugs and non-Formulary brand name diabetic supplies for which there is no generic drug or supply available	$ per prescription	
— If your Physician indicates dispense as written on the prescription, you will be responsible for the Copayment amount specified above and the following provision will not apply.		0.452e1
— Non-Formulary brand name drugs and non-Formulary brand name diabetic supplies for which there is a generic drug or supply available	$, plus the cost difference between the generic and brand name drugs or supplies per prescription	0.452e
— Self-injectable drugs other than insulin and infertility drugs	$ per prescription	0.454
Copayment for Specialty Drugs	$ per prescription	0.452e2
Copayment for drugs and supplies (other than Specialty Drugs)		
— Generic drugs and generic diabetic supplies and diabetic supplies	$ per prescription	

— Brand name drugs and brand name diabetic supplies for which there is no generic drug or supply available	$ per prescription	
— If your Physician indicates dispense as written on the prescription, you will be responsible for the Copayment amount specified above and the following provision will not apply.		0.452f1
— Brand name drugs and brand name diabetic supplies for which there is a generic drug or supply available	$, plus the cost difference between the generic and brand name drugs or supplies per prescription	0.452f
Copayment for Specialty Drugs	$ per prescription	0.452f2
Payment level for drugs and supplies		
— Drugs and diabetic supplies (other than Specialty Drugs)	% of the Eligible Charge per prescription	0.460
— Specialty Drugs	% of the Eligible Charge per prescription	0.460a
Payment level for drugs and supplies (other than Specialty Drugs)		
— Generic drugs and generic diabetic supplies and diabetic supplies (other than Specialty Drugs)	% of the Eligible Charge per prescription	0.452g1
— Generic drugs and generic diabetic supplies and diabetic supplies (other than Specialty Drugs)	$ per prescription	0.452g2
— Formulary brand name drugs and Formulary brand name diabetic supplies (other than Specialty Drugs)	% of the Eligible Charge per prescription	
— Non-Formulary brand name drugs and non-Formulary brand name diabetic supplies (other than Specialty Drugs) for which there is no generic drug or supply available	% of the Eligible Charge per prescription	

— If your Physician indicates dispense as written on the prescription, you will be responsible for the Coinsurance amount specified above and the following provision will not apply.		0.452g3
— Non-Formulary brand name drugs and non-Formulary brand name diabetic supplies (other than Specialty Drugs) for which there is a generic drug or supply available	% of the Eligible Charge, plus the cost difference between the generic and brand name drugs or supplies per prescription	0.452g
Payment level for Specialty Drugs	% of the Eligible Charge per prescription	0.452g4
Maximum Coinsurance		0.452g5
— Generic drugs and generic diabetic supplies and diabetic supplies (other than Specialty Drugs)	$ per prescription	0.452g5
— Formulary brand name drugs and Formulary brand name diabetic supplies (other than Specialty Drugs)	$ per prescription	0.452g5
— Non-Formulary brand name drugs and non-Formulary brand name diabetic supplies (other than Specialty Drugs)	$ per prescription	0.452g5
— Specialty Drugs	$ per prescription	0.452g6
Minimum Coinsurance		0.452g5
— Generic drugs and generic diabetic supplies and diabetic supplies (other than Specialty Drugs)	$ per prescription	0.452g5
— Formulary brand name drugs and Formulary brand name diabetic supplies (other than Specialty Drugs)	$ per prescription	0.452g5
— Non-Formulary brand name drugs and non-Formulary brand name diabetic supplies (other than Specialty Drugs)	$ per prescription	0.452g5
— Specialty Drugs	$ per prescription	0.452g6
Out-of-Pocket Limit		0.456
— Maximum	$ per prescription	

— Minimum	$ per prescription	
Home Delivery Prescription Drug Program		0.453
Copayment		
— Drugs and diabetic supplies (other than Specialty Drugs)	$ per prescription	
— Specialty Drugs	$ per prescription	0.453a2
Copayment for drugs and supplies (other than Specialty Drugs)		
— Generic drugs and generic diabetic supplies or brand name drugs and brand name diabetic supplies for which there is no generic drug or supply available	$ per prescription	
— Brand name drugs and brand name diabetic supplies	$ per prescription	0.453b
— self-injectable drugs	$ per prescription	0.4532
— oral contraceptives	$ per prescription	0.4531
Copayment for Specialty Drugs	$ per prescription	0.453b1
Copayment for drugs and supplies (other than Specialty Drugs)		
— Generic drugs and generic diabetic supplies and diabetic supplies	$ per prescription	
— Formulary brand name drug and Formulary brand name diabetic supplies	$ per prescription	
— Non-Formulary brand name drug and non-Formulary brand name diabetic supplies	$ per prescription	0.453c
— Self-injectable drugs other than insulin and infertility drugs	$ per prescription	0.453c1
Copayment for Specialty Drugs	$ per prescription	0.453c2
Copayment for drugs and supplies (other than Specialty Drugs)		
— Generic drugs and generic diabetic supplies and diabetic supplies	$ per prescription	
— Formulary brand name drugs and Formulary brand name diabetic supplies	$ per prescription	

— Non-Formulary brand name drugs and non-Formulary brand name diabetic supplies for which there is no generic drug or supply available	$ per prescription	
— If your Physician indicates dispense as written on the prescription, you will be responsible for the Coinsurance amount specified above and the following provision will not apply.		0.453h1
— Non-Formulary brand name drugs and non-Formulary brand name diabetic supplies for which there is a generic drug or supply available	$, plus the cost difference between the generic and brand name drugs or supplies per prescription	0.453h
Copayment for Specialty Drugs	$ per prescription	0.453h2
Copayment for drugs and supplies (other than Specialty Drugs)		
— Generic drugs and generic diabetic supplies and diabetic supplies	$ per prescription	
— Brand name drugs and brand name diabetic supplies for which there is no generic drug or supply available	$ per prescription	
— Brand name drugs and brand name diabetic supplies for which there is a generic drug or supply available	$ per prescription	0.453d
Copayment for Specialty Drugs	$ per prescription	0.453d1
Copayment for drugs and supplies (other than Specialty Drugs)		
— Generic drugs and generic diabetic supplies and diabetic supplies	$ per prescription	
— Brand name drugs and brand name diabetic supplies for which there is no generic drug or supply available	$ per prescription	
— If your Physician indicates dispense as written on the prescription, you will be responsible for the Copayment amount specified above and the following provision will not apply.		0.453f1

— Brand name drugs and brand name diabetic supplies for which there is a generic drug or supply available	$, plus the cost difference between the generic and brand name drugs or supplies per prescription	0.453f
Copayment for Specialty Drugs	$ per prescription	0.453f2
Payment level for drugs and supplies		
— Drugs and diabetic supplies (other than Specialty Drugs)	% of the Eligible Charge per prescription	
— Specialty Drugs	% of the Eligible Charge per prescription	0.460b1
Payment level for drugs and supplies (other than Specialty Drugs)		
— Generic drugs and generic diabetic supplies and diabetic supplies	% of the Eligible Charge per prescription	0.453e1
— Generic drugs and generic diabetic supplies and diabetic supplies	$ per prescription	0.453e2
— Formulary brand name drugs and Formulary brand name diabetic supplies	% of the Eligible Charge per prescription	
— Non-Formulary brand name and non-Formulary brand name diabetic supplies	% of the Eligible Charge per prescription	0.453e
Payment level for Specialty Drugs	% of the Eligible Charge per prescription	0.453e3
Payment level for drugs and supplies (other than Specialty Drugs)		
— Generic drugs and generic diabetic supplies and diabetic supplies	% of the Eligible Charge per prescription	0.453g1
— Generic drugs and generic diabetic supplies and diabetic supplies	$ per prescription	0.453g2
— Formulary brand name drugs and Formulary brand name diabetic supplies	% of the Eligible Charge per prescription	

— Non-Formulary brand name drugs and non-Formulary brand name diabetic supplies for which there is no generic drug or supply available	% of the Eligible Charge per prescription	
— If your Physician indicates dispense as written on the prescription, you will be responsible for the Coinsurance amount specified above and the following provision will not apply.		0.453g3
— Non-Formulary brand name drugs and non-Formulary brand name diabetic supplies for which there is a generic drug or supply available	% of the Eligible Charge, plus the cost difference between the generic and brand name drugs or supplies per prescription	0.453g
Payment level for Specialty Drugs	% of the Eligible Charge per prescription	0.453g7
Maximum Coinsurance		0.453g6
— Generic drugs and generic diabetic supplies and diabetic supplies (other than Specialty Drugs)	$ per prescription	
— Formulary brand name drugs and Formulary brand name diabetic supplies (other than Specialty Drugs)	$ per prescription	
— Non-Formulary brand name drugs and non-Formulary brand name diabetic supplies (other than Specialty Drugs)	$ per prescription	
— Specialty Drugs	$ per prescription	0.453g5
Minimum Coinsurance		0.453g6
— Generic drugs and generic diabetic supplies (other than Specialty Drugs)	$ per prescription	
— Formulary brand name drugs and Formulary brand name diabetic supplies (other than Specialty Drugs)	$ per prescription	
— Non-Formulary brand name drugs and non-Formulary brand name diabetic supplies (other than Specialty Drugs)	$ per prescription	

— Specialty Drugs	$ per prescription	0.453g5
Out-of-Pocket Limit		0.457
— Maximum	$ per prescription	
— Minimum	$ per prescription	
Your prescription drug program benefits are specified in the "Rider to the Certificate For Outpatient Prescription Drug Program" (an insert) of this Certificate.		0.459

PRESCRIPTION DRUG PROGRAM

Participating Prescription Drug Provider:		
— Individual Deductible	$ per benefit period	0.531
— Family Deductible	$ per benefit period	0.5311
Payment Level		
— generic drugs	% of the Claim Charge	0.533
— brand name drugs	% of the Average Wholesale Price	0.534
Non-Participating Prescription Drug Provider:		
— Individual Deductible	$ per benefit period	0.535
— Family Deductible	$ per benefit period	0.536
Payment Level		
— generic drugs	% of the Average Wholesale Price	0.537
— brand name drugs	% of the Average Wholesale Price	0.538
Benefit Maximum		
— Individual	$ per benefit period	
— Family	$ per benefit period	0.539

DENTAL BENEFITS		0.47
Deductible	$ per benefit period	0.471
Family Deductible	individual deductibles	0.472
Deductible		
— Participating Provider	$ per benefit periodNone	
— Non-Participating Provider	$ per benefit period	0.4711
Family Deductible	individual deductibles$ per benefit period	0.4712a
Family Deductible		
— Participating Provider	$ per benefit periodNone	
— Non-Participating Provider	$ per benefit period	0.4712b
Preventive Services Benefit Payment Level	% of the U&C Fee*	0.473
Primary Services Benefit Payment Level	% of the U&C Fee*	0.474
Major Services Benefit Payment Level	% of the U&C Fee*	0.475
Benefit Period Maximum	$	0.476
Orthodontic Services Benefit Payment Level	% of the U&C Fee*	0.477
Orthodontics Lifetime Maximum	$	0.478
DENTAL BENEFITS		0.4111
Individual Deductible	$ per benefit period	0.4119
Family Deductible	3 individual deductibles	0.4120
Maximum	$ per benefit period	0.4112
Basic Benefit Payment Level		0.4113
Additional Basic Benefit Payment Level		0.4114
Prosthodontic Benefit Payment Level		0.4115
Periodontic Benefit Payment Level		0.4116
Orthodontic Benefit Payment Level		0.4117
Orthodontic Maximum Per Course of Treatment	$	0.4118

Preventive Services Benefit Payment Level		
— Participating Provider	% of the Maximum Allowance	
— Non-Participating Provider	% of the Maximum AllowanceU&C Fee*	0.4713
Primary Services Benefit Payment Level		
— Participating Provider	% of the Maximum Allowance	
— Non-Participating Provider	% of the Maximum AllowanceU&C Fee*	0.4714
Major Services Benefit Payment Level		
— Participating Provider	% of the Maximum Allowance	
— Non-Participating Provider	% of the Maximum AllowanceU&C Fee*	0.4715
Benefit Period Maximum	$	0.4716
Orthodontic Services Benefit Payment Level		
— Participating Provider	% of the Maximum Allowance	
— Non-Participating Provider	% of the Maximum AllowanceU&C Fee*	0.4717
Orthodontics Lifetime Maximum	$	0.4718
DENTAL BENEFITS		0.77
[Benefit Waiting Period	[None]	0.7300
[You must be continuously covered for the specified number of months before you are eligible to receive benefits for the following Covered Services:[		0.7301
• General Dental Services	[1–24] month(s)][	0.7302
• Endodontic Services	[1–24] month(s)][	0.7303
• Periodontic Services	[1–24] month(s)][	0.7304
• Oral Surgery Services	[1–24] month(s)][	0.7305
• Crowns, Inlays/Onlays Services	[1–24] month(s)][	0.7306
• Prosthodontic Services	[1–24] month(s)][	0.7307
• Implants	[1–24] month(s)][	0.7308
• Temporomandibular Joint Services	[1–24] month(s)][	0.7309
• Orthodontic Dental Services	[1–24] month(s)]]	0.7310
Deductible	$ per benefit period	0.771
Family Deductible	individual deductibles	0.772

Deductible		
— Participating Provider	$ per benefit periodNone	
— Non-Participating Provider	$ per benefit period	0.7711
Family Deductible	individual deductibles$ per benefit period	0.7712a
Family Deductible		
— Participating Provider	$ per benefit periodNone	
— Non-Participating Provider	$ per benefit period	0.7712b
Diagnostic and Preventive Dental Services Benefit Payment Level	% of the U&C Fee*	0.7201
Miscellaneous Dental Services Benefit Payment Level	% of the U&C Fee*	0.7202
Restorative Dental Services Benefit Payment Level	% of the U&C Fee*	0.7203
General Dental Services Benefit Payment Level	% of the U&C Fee*	0.7204
Endodontic Services Benefit Payment Level	% of the U&C Fee*	0.7205
Periodontic Services Benefit Payment Level	% of the U&C Fee*	0.7206
Oral Surgery Services Benefit Payment Level	% of the U&C Fee*	0.7207
Crowns, Inlays/Onlays Services Benefit Payment Level	% of the U&C Fee*	0.7208
Prosthodontic Services Benefit Payment Level	% of the U&C Fee*	0.7209
Implants Benefit Payment Level	% of the U&C Fee*	0.7210
Temporomandibular Joint Services Benefit Payment Level	% of the U&C Fee*	0.7211
Benefit Period Maximum	$	0.7212
Orthodontic Dental Services Benefit Payment Level	% of the U&C Fee*	0.7213
Orthodontic Dental Services Lifetime Maximum	$	0.7214
Diagnostic and Preventive Dental Services Benefit Payment Level		
— Participating Provider	% of the Maximum Allowance	

— Non-Participating Provider	% of the Maximum AllowanceU&C Fee*	0.7101
Miscellaneous Dental Services Benefit Payment Level		
— Participating Provider	% of the Maximum Allowance	
— Non-Participating Provider	% of the Maximum AllowanceU&C Fee*	0.7102
Restorative Dental Services Benefit Payment Level		
— Participating Provider	% of the Maximum Allowance	
— Non-Participating Provider	% of the Maximum AllowanceU&C Fee*	0.7103
General Dental Services Benefit Payment Level		
— Participating Provider	% of the Maximum Allowance	
— Non-Participating Provider	% of the Maximum AllowanceU&C Fee*	0.7104
Endodontic Services Benefit Payment Level		
— Participating Provider	% of the Maximum Allowance	
— Non-Participating Provider	% of the Maximum AllowanceU&C Fee*	0.7105
Periodontic Services Benefit Payment Level		
— Participating Provider	% of the Maximum Allowance	
— Non-Participating Provider	% of the Maximum AllowanceU&C Fee*	0.7106
Oral Surgery Services Benefit Payment Level		
— Participating Provider	% of the Maximum Allowance	
— Non-Participating Provider	% of the Maximum AllowanceU&C Fee*	0.7107
Crowns, Inlays/Onlays Services Benefit Payment Level		
— Participating Provider	% of the Maximum Allowance	
— Non-Participating Provider	% of the Maximum AllowanceU&C Fee*	0.7108
Prosthodontic Services Benefit Payment Level		
— Participating Provider	% of the Maximum Allowance	
— Non-Participating Provider	% of the Maximum AllowanceU&C Fee*	0.7109
Implants Benefit Payment Level		
— Participating Provider	% of the Maximum Allowance	
— Non-Participating Provider	% of the Maximum AllowanceU&C Fee*	0.7110
Temporomandibular Joint Services Benefit Payment Level		
— Participating Provider	% of the Maximum Allowance	

— Non-Participating Provider	% of the Maximum AllowanceU&C Fee*	0.7111
Benefit Period Maximum	$	0.7112
Benefit Period Maximum		
— Participating Provider	$	
— Non-Participating Provider	$	0.7115
[Graduated Benefit Period Maximum Increment	[None][$[5–500], limited to a maximum of [one–10] incremental increase(s)]	0.7116
Orthodontic Dental Services Benefit Payment Level		
— Participating Provider	% of the Maximum Allowance	
— Non-Participating Provider	% of the Maximum AllowanceU&C Fee*	0.7113
Orthodontic Dental Services Lifetime Maximum	$	0.7114

[NOTE: 0.7117

[If you are pregnant, benefits for one additional prophylaxis treatment and one additional periodontal maintenance procedure will be provided at 100% of the Maximum Allowance.] 0.7117a

[If you are pregnant or diagnosed with diabetes or heart disease, benefits for periodontal scaling and root planing will be provided at 100% of the Maximum Allowance.] 0.7117b

VISION BENEFITS		0.6111
Benefit Payment Level	% of the U&C Fee* limited to $ per benefit period	0.6111a 0.6111a1
Vision Examination	$ 16 per exam	
Single Vision Lenses	$ 14 per pair	
Bifocal Lenses	$ 25 per pair	
Trifocal Lenses	$ 35 per pair	
Lenticular Lenses	$ 70 per pair	
Contact Lenses	$ 70 per pair	
Frames	$ 14 per Frame	0.6111b
Vision Examination	$ 25 per exam	
Single Vision Lenses	$ 20 per pair	
Bifocal Lenses	$ 35 per pair	
Trifocal Lenses	$ 40 per pair	
Lenticular Lenses	$100 per pair	
Contact Lenses	$100 per pair	
Frames	$ 20 per Frame	0.6111c
Vision Examination	$ 32 per exam	
Single Vision Lenses	$ 28 per pair	
Bifocal Lenses	$ 50 per pair	
Trifocal Lenses	$ 70 per pair	
Lenticular Lenses	$140 per pair	
Contact Lenses	$140 per pair	
Frames	$ 28 per Frame	0.6111d
Vision Examination	$ per exam	0.6112
Single Vision Lenses	$ per pair	0.6112a
Bifocal Lenses	$ per pair	0.6112a
Trifocal Lenses	$ per pair	0.6112a
Lenticular Lenses	$ per pair	0.6112a
Lenses (other than Contact Lenses)	$ per pair	0.6112b
Contact Lenses	$ per pair	0.6113
Frames	$ per Frame	0.6114
HEARING BENEFITS		0.6211

Benefit Payment Level	% of the U&C Fee* limited to $ per benefit period	0.6211a 0.6211a1
Hearing Aids Lifetime Maximum	$	0.6211b
Audiometric Exam		
— By a physician	$12	
— By an audiologist	$10	
Hearing Aid Evaluation	$10	
Conformity Evaluation	$ 3	
Hearing Aids		
— On-the-body	$120	
— In-the-ear	$115	
— Behind-the-ear	$125	
— Eyeglass type	$125	0.62112
Audiometric Exam		
— By a physician	$17	
— By an audiologist	$15	
Hearing Aid Evaluation	$15	
Conformity Evaluation	$ 5	
Hearing Aids		
— On-the-body	$170	
— In-the-ear	$160	
— Behind-the-ear	$180	
— Eyeglass type	$180	0.62113
Audiometric Exam		
— By a physician	$24	
— By an audiologist	$21	
Hearing Aid Evaluation	$21	
Conformity Evaluation	$ 7	
Hearing Aids		
— On-the-body	$240	
— In-the-ear	$225	
— Behind-the-ear	$255	
— Eyeglass type	$255	0.62114
Audiometric Exam		

— By a physician	$	
— By an audiologist	$	
Hearing Aid Evaluation	$	
Conformity Evaluation	$	
Hearing Aids		
— On-the-body	$	
— In-the-ear	$	
— Behind-the-ear	$	
— Eyeglass type	$	0.62115

MEDICARE SUPPLEMENTAL INPATIENT HOSPITAL BENEFITS		
Number of Hospital Days available	820	
Benefit Payment Level		
— 1st to 60th Day	Medicare Deductible Amount	
— 61st to 90th Day	Medicare Co-Payment Amount	
— 91st to 820th Day	Medicare Co-Payment Amount	
MEDICARE SUPPLEMENTAL INPATIENT SKILLED NURSING FACILITY BENEFITS		
Number of Benefit Days available	80	
— Benefit Payment Level	Medicare Co-Payment Amount	
MEDICARE SUPPLEMENTAL OUTPATIENT HOSPITAL BENEFITS		
Benefit Payment Level	100% of the Eligible Charge (until Medicare Deductible met, then 20%)	
MEDICARE SUPPLEMENTAL SURGICAL/MEDICAL BENEFITS		
Benefit Payment Level	20% of U&C Fee*	
Number of Inpatient Medical Visits	Unlimited	0.48

ANNUAL DEDUCTIBLE 0.4834 Plan F High Ded.

Benefits will begin under this Certificate after you have claims for Medicare Eligible Expenses in a calendar year that are more than $[]. **Revised**

OUT-OF-POCKET LIMIT 0.482 Plans K & L

Once you meet the annual out-of-pocket limit of $[], this coverage pays 100% of the Medicare Part A and Part B Copayments, Coinsurance and deductibles for the rest of the calendar year. **Revised**

INPATIENT HOSPITAL BENEFITS

Benefit Payment Level		0.480	
— 1st to 60th Day	No Benefits	0.48311	Plan A
— 1st to 60th Day	Medicare Deductible Amount	0.4831	Plans B–F, J
— 1st to 60th Day	50% of the Medicare Deductible Amount	0.4832	Plan K
— 1st to 60th Day	75% of the Medicare Deductible Amount	0.4833	Plan L
— 61st to 90th Day	Medicare Copayment Amount	0.480	All Plans
— 91st to 150th Day	Medicare Copayment Amount	0.480	All Plans
Benefit Payment Level for Additional Hospital Days (beginning on 151st Day)	100% of the Medicare Eligible Expenses for a Lifetime Maximum of 365 Days	0.480	All Plans
INPATIENT SKILLED NURSING FACILITY BENEFITS			
Number of Benefit Days available	80	0.484	
Benefit Payment Level	Medicare Copayment Amount	0.4841	Plans C–F, J
Benefit Payment Level	50% of the Medicare Copayment Amount	0.4832	Plan K
Benefit Payment Level	75% of the Medicare Copayment Amount	0.4833	Plan L
HOSPICE CARE AND INPATIENT RESPITE CARE BENEFITS		0.482	
Benefit Payment Level	50% of the Medicare Coinsurance or Copayment Amount	0.4832	Plan K
Benefit Payment Level	75% of the Medicare Coinsurance or Copayment Amount	0.4833	Plan L
MEDICAL BENEFITS			
Benefit Payment Level	20% of the Medicare Eligible Expenses after the Medicare Part B Deductible met	0.4861	Plans A, B, D, E
Benefit Payment Level	10% of the Medicare Eligible Expenses after the Medicare Part B Deductible met	0.4832	Plan K
Benefit Payment Level	15% of the Medicare Eligible Expenses after the Medicare Part B Deductible met	0.4833	Plan L
Benefit Payment Level	100% of the Medicare Eligible Expenses until the Medicare Part B Deductible met, then 20%	0.4863	Plan C, F, J

PREVENTIVE MEDICAL CARE BENEFITS		0.482	Plans K & L
Benefit Payment Level	100% of the Medicare Eligible Expenses until the Medicare Part B Deductible met, then 20%		
OUTPATIENT HOSPITAL BENEFITS		0.480	
Benefit Payment Level	100% of the Medicare Copayment Amount	0.4881	Plans A–F, J
Benefit Payment Level	50% of the Medicare Copayment Amount	0.4832	Plan K
Benefit Payment Level	75% of the Medicare Copayment Amount	0.4833	Plan L
EMERGENCY CARE BENEFITS IN A FOREIGN COUNTRY		0.4841	Plans C–F, J
Benefit Payment Level	80% of the Eligible Charges after $250 Calendar Year Deductible		
Lifetime Benefit Maximum	$50,000		
AT-HOME RECOVERY BENEFITS		0.487	Plan D, J
Benefit Payment Level	100% of the Eligible Charge up to $40 each Visit		
Benefit Maximum	7 Visits each Week up to $1,600 each Calendar Year		
PREVENTIVE MEDICAL CARE BENEFITS		0.489	Plan E, J
Benefit Payment Level	100% of the Medicare-Approved Amount		
Benefit Maximum	$120 each Calendar Year		

†the Hospital's most common semi-private room rate	0.49a
*Usual and Customary Fee	0.49b
*Usual and Customary Fee	UCF

TO IDENTIFY NON-PLAN AND PLAN HOSPITALS OR FACILITIES, YOU SHOULD CONTACT BLUE CROSS AND BLUE SHIELD BY CALLING THE CUSTOMER SERVICE TOLL-FREE TELEPHONE NUMBER ON YOUR BLUE CROSS AND BLUE SHIELD IDENTIFICATION CARD.

**Should the Federal Government adjust the Deductible and/or the Out-of-Pocket Expense Limit amount(s) for High Deductible Health Plans as defined by the Internal Revenue Code, the Deductible and/or the Out-of-Pocket Expense Limit amount(s) in this Certificate will be adjusted accordingly.	HSA

DEFINITIONS SECTION

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

[ADVANCED PRACTICE NURSE.....means a Certified Clinical Nurse Specialist, Certified Nurse-Midwife, Certified Nurse Practitioner or Certified Registered Nurse Anesthetist.]

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

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

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

A "Non-Plan Ambulatory Surgical Facility" means an Ambulatory Surgical Facility which does not meet the definition of a Plan Ambulatory Surgical Facility.

[A "Participating Ambulatory Surgical Facility" means a Plan Ambulatory Surgical Facility which has a written agreement with Blue Cross and Blue Shield to provide services to participants in the [Participating Option][Community Blue] program.

A "Non-Participating Ambulatory Surgical Facility" means a Plan Ambulatory Surgical Facility which does not have a written agreement with Blue Cross and Blue Shield to provide services to participants in the [Participating Option][Community Blue] program.]]

0.3P

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

[ANNUAL DEDUCTIBLE.....means the amount of expense that you must incur in Covered Services Out-of-Network each calendar year before Out-of-Network bene-

fits will be provided under this Certificate. The deductible will not include any expense in excess of the Eligible Charge or Maximum Allowance.] 0.46M

[AUTISM SPECTRUM DISORDER(S).....means pervasive developmental disorders as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, including autism, Asperger's disorder and pervasive developmental disorders not otherwise specified.] **New 10/09**

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

[BEHAVIORAL HEALTH PRACTITIONER.....means a Physician[or[Professional] Provider] who is duly licensed to render services for [Mental Illness,] Serious Mental Illness or Substance Abuse disorders.] 0.3BHP **MHP Final Regs 7/1/10 & after**

[BENEFIT PERIOD.....means a period that begins on the first day of Inpatient Hospital care and ends after you have been out of the Hospital and have not received care in a Skilled Nursing Facility for 60 days in a row.] Applicable to Medicare Supplement only

[BENEFIT WAITING PERIOD.....means the number of months that you must be continuously covered under this benefit program before you are eligible to receive benefits for certain dental Covered Services.[If you have a Benefit Waiting Period, it is listed in your Benefit Highlights (an insert) to this Certificate.]] 0.3WP; 0.3WPI

[BLUE*CHOICE*®.....means the point of service health care benefit program established by Blue Cross and Blue Shield based upon a network of selected Providers. The Blue*Choice* benefit program includes benefit incentives for you to receive Covered Services In-Network.] 0.46M

[BLUE*CHOICE*®.....means a network of selected Providers established by Blue Cross and Blue Shield.]

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

[CERTIFICATE OF CREDITABLE COVERAGE.....means a certificate disclosing information relating to your Creditable Coverage under a health care benefit program for purposes of reducing any Preexisting Condition exclusion imposed by any group health plan coverage.]

[CERTIFIED CLINICAL NURSE SPECIALIST.....means a nurse specialist who (a) is licensed under the Nursing and Advanced Practice Nursing Act; (b) has an arrangement or agreement with a Physician for obtaining medical consultation, collaboration and hospital referral and (c) meets the following qualifications:

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

(ii) is a graduate of an advanced practice nursing program.

[A "Participating Certified Clinical Nurse Specialist" means a Certified Clinical Nurse Specialist who has a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A "Non-Participating Certified Clinical Nurse Specialist" means a Certified Clinical Nurse Specialist who does not have a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.]]

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

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

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

[A "Participating Certified Nurse-Midwife" means a Certified Nurse-Midwife who has a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A "Non-Participating Certified Nurse-Midwife" means a Certified Nurse-Midwife who does not have a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.]]

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

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

(ii) is a graduate of an advanced practice nursing program.

[A "Participating Certified Nurse Practitioner" means a Certified Nurse Practitioner who has a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A "Non-Participating Certified Nurse Practitioner" means a Certified Nurse Practitioner who does not have a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.]]

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

[A "Participating Certified Registered Nurse Anesthetist" means a Certified Registered Nurse Anesthetist who has a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A "Non-Participating Certified Registered Nurse Anesthetist" means a Certified Registered Nurse Anesthetist who does not have a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.]]

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

[CHIROPRACTOR.....means a duly licensed chiropractor.]

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

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

CLAIM PAYMENT.....means the benefit payment calculated by Blue Cross and Blue Shield, after submission of a Claim, in accordance with the benefits described in this Certificate. All Claim Payments will be calculated on the basis of the Eligible

Charge for Covered Services rendered to you, regardless of any separate financial arrangement between Blue Cross and Blue Shield and a particular Provider. (See provisions of this Certificate regarding "Blue Cross and Blue Shield's Separate Financial Arrangements with [Prescription Drug]Providers.")

[CLINICAL LABORATORY.....means a clinical laboratory which complies with the licensing and certification requirements under the Clinical Laboratory Improvement Amendments of 1988, the Medicare and Medicaid programs and any applicable state and local statutes and regulations.

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

A "Non-Participating Clinical Laboratory" means a Clinical Laboratory which does not have a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.]]

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

[A "Participating Clinical Professional Counselor" means a Clinical Professional Counselor who has a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A "Non-Participating Clinical Professional Counselor" means a Clinical Professional Counselor who does not have a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.]]

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

[A "Participating Clinical Social Worker" means a Clinical Social Worker who has a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A "Non-Participating Clinical Social Worker" means a Clinical Social Worker who does not have a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.]

[COBRA.....means 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 Eligible Persons whose coverage would otherwise terminate under the terms of this Certificate.]

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

[COMMUNITY BLUE.....means a program of health care benefits designed to provide you with economic incentives for using designated Providers of health care services.] 0.3CB

[COMMUNITY PARTICIPATING OPTION.....means the Participating Provider Option program with an additional feature designed to provide you with economic incentives for using designated Providers of health care services in your local community.] CPO

[COMMUNITY PROFESSIONAL PROVIDER.....SEE DEFINITION OF PROVIDER.] CPO

[COMMUNITY PROVIDER.....SEE DEFINITION OF PROVIDER.] CPO

[COMMUNITY PROVIDER HOSPITAL.....SEE DEFINITION OF PROVIDER.] CPO

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

[CONGENITAL OR GENETIC DISORDER.....means a disorder that includes, but is not limited to, hereditary disorders, Congenital or Genetic Disorders may also include, but are not limited to, Autism or an Autism Spectrum Disorder, cerebral palsy, and other disorders resulting from early childhood illness, trauma or injury.] **New 10/09**

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

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

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

[A "Participating Coordinated Home Care Program" means a Plan Coordinated Home Care Program which has a written agreement with Blue Cross and Blue Shield to provide services to participants in the [Participating Option][Community Blue] program. 0.3P

A "Non-Participating Coordinated Home Care Program" means a Plan Coordinated Home Care Program which does not have a written agreement with Blue

Cross and Blue Shield to provide services to participants in the [Participating Option][Community Blue] program.]] 0.3P

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

[COURSE OF TREATMENT.....means any number of dental procedures or treatments performed by a Dentist [or Physician]in a planned series resulting from a dental examination in which the need for such procedures or treatments was determined.]

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

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

[CREDITABLE COVERAGE.....means coverage you had under any of the following:

(i) A group health plan.

(ii) Health insurance coverage for medical care under any hospital or medical service policy or certificate, hospital or medical service plan contract, or HMO contract offered by a health insurance issuer.

(iii) Medicare (Parts A or B of Title XVIII of the Social Security Act).

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

(v) Medical care for members and certain former members of the uniformed services and their dependents.

(vi) A medical care program of the Indian Health Service or of a tribal organization.

(vii) A State health benefits risk pool.

(viii) A health plan offered under the Federal Employees Health Benefits Program.

(ix) 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.

(x) A health benefit plan under section 5(e) of the Peace Corps Act.

(xi) State Children's Health Insurance Program (Title XXI of the Social Security Act).]

[CUSTODIAL CARE SERVICE.....means any service primarily for personal comfort or convenience that provides general maintenance, preventive, and/or protective care without any clinical likelihood of improvement of your condition. Custodial Care Services also means those services which do not require the technical skills, professional training and clinical assessment ability of medical and/or nursing personnel in order to be safely and effectively performed. These services can be safely provided by trained or capable non-professional personnel, are to assist with

routine medical needs (e.g. simple care and dressings, administration of routine medications, etc.) and are to assist with activities of daily living (e.g. bathing, eating, dressing, etc.). Custodial Care Service also means providing care on a continuous Inpatient or Outpatient basis without any clinical improvement by you.]

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

[A "Participating Dentist" means a Dentist who has a written agreement with Blue Cross and Blue Shield of Illinois or the entity chosen by Blue Cross and Blue Shield to administer a Participating Provider Option Dental program to provide services to you at the time you receive the services. 0.3DP

A "Non-Participating Dentist" means a Dentist who does not have a written agreement with Blue Cross and Blue Shield of Illinois or the entity chosen by Blue Cross and Blue Shield to administer a Participating Provider Option Dental program to provide services to participants in the Participating Provider Option program.]] 0.3DP

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

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

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

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

[DOMESTIC PARTNER.....means a person with whom you have entered into a Domestic Partnership. D.47

DOMESTIC PARTNERSHIP.....means long-term committed relationship of indefinite duration with a person which meets the following criteria:

(i) you and your Domestic Partner have lived together for at least [6–18] months,

(ii) neither you nor your Domestic Partner is married to anyone else or has another domestic partner,

(iii) your Domestic Partner is at least 18 years of age and mentally competent to consent to contract,

(iv) your Domestic Partner resides with you and intends to do so indefinitely,

(v) you and your Domestic Partner have an exclusive mutual commitment similar to marriage, and

(vi) you and your Domestic Partner are jointly responsible for each other's common welfare and share financial obligations.] D.47

[DURABLE MEDICAL EQUIPMENT PROVIDER.....means a duly licensed durable medical equipment provider.

[A "Participating Durable Medical Equipment Provider" means a Durable Medical Equipment Provider who has a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A "Non-Participating Durable Medical Equipment Provider" means a Durable Medical Equipment Provider who does not have a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.]]

[EARLY ACQUIRED DISORDER.....means a disorder resulting from illness, trauma, injury, or some other event or condition suffered by a child prior to that child developing functional life skills such as, but not limited to, walking, talking or self–help skills. Early Acquired Disorder may include, but is not limited to, Autism or an Autism Spectrum Disorder and cerebral palsy.] **New 10/09**

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

(i) the charge which is within the range of charges other similar Hospitals or facilities in similar geographic areas charge their patients for the same or similar services, as reasonably determined by Blue Cross and Blue Shield, if available, **Base +, CMM, PPO Hospital Only – prior to 1/1/11**

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

(iii) the charge which the particular Hospital or facility usually charges its patients for Covered Services.] 0.35a

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

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

PPO Plus – prior to 1/1/11

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

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

0.35b

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

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

BCS – prior to 1/1/11

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

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

0.35b

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

CMM & PPO Hosp only

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

(ii) the Blue Cross and Blue Shield of Illinois non-contracting Eligible Charge. Except as otherwise provided in this section, the non-contracting Eligible Charge is developed from base Medicare reimbursements and represents approximately [60–100]100% of the base Medicare reimbursement rate and will exclude any Medicare adjustment(s) which is/are based on information on the Claim.

[Notwithstanding the preceding sentence, the non-contracting Eligible Charge for Coordinated Home Care Program Covered Services will be [50–90]50% of the

[Non-Participating or]Non-Plan Provider's standard billed charge for such Covered Services.]

[The Eligible Charge, as is appropriate under the circumstances, for the following Covered Services shall be:[

— [60–1000]% of the base Medicare reimbursement rate for Inpatient facility Claims][

— [60–1000]% of the base Medicare reimbursement rate for Outpatient facility Claims][

— [60–1000]% of the base Medicare reimbursement rate for free-standing Ambulatory Surgical Facility Claims][

— [60–1000]% of the base Medicare reimbursement rate for Skilled Nursing Facility Claims][

— [60–1000]% of the base Medicare reimbursement rate for laboratory Claims][

— [60–1000]% of the base Medicare reimbursement rate for all other types of Claims][

The base Medicare reimbursement rate described above will exclude any Medicare adjustment(s) which is/are based on information on the Claim.]

When a Medicare reimbursement rate is not available for a Covered Service or is unable to be determined on the information submitted on the Claim, the Eligible Charge for [Non-Participating or]Non-Plan Providers will be [50–90]50% of the [Non-Participating or]Non-Plan Provider's standard billed charge for such Covered Service.

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

Any change to the Medicare reimbursement amount will be implemented by Blue Cross and Blue Shield of Illinois within [90–145]145 days after the effective date that such change is implemented by the Centers for Medicaid and Medicare Services, or its successor.

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

or another Blue Cross and/or Blue Shield Plan to provide care to you at the time Covered Services are rendered, will be the lesser of:

Base +, CMM, PPO Hospital Only 1/1/11 & after

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

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

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

The base Medicare reimbursement rate described above will exclude any Medicare adjustment(s) which is/are based on information on the Claim.

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

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

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

PPO Plus & CPO – 1/1/11 & after

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

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

(ii) Blue Cross and Blue Shield of Illinois non-contracting Eligible Charge. Except as otherwise provided in this section, the non-contracting Eligible Charge is developed from base Medicare reimbursements and represents approximately 100% of the base Medicare reimbursement rate and will

exclude any Medicare adjustment(s) which is/are based on information on the Claim.

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

The base Medicare reimbursement rate described above will exclude any Medicare adjustment(s) which is/are based on information on the Claim.

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

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

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

[ELIGIBLE CHARGE.....means (a) in the case of a Provider which has a written agreement with a Blue Cross and Blue Shield Plan or the entity chosen by Blue Cross and Blue Shield to administer its prescription drug program to provide Covered Services to you at the time you receive the Covered Services, such Provider's Claim Charge for Covered Services and (b) in the case of a Provider which does not have a written agreement with a Blue Cross and Blue Shield Plan or the entity chosen by Blue Cross and Blue Shield to provide services to you at the time you receive Covered Services, either of the following charges for Covered Services:

(i) the charge which the particular Prescription Drug Provider usually charges for Covered Services, or

(ii) the agreed upon cost between Participating Prescription Drug Providers and a Blue Cross and Blue Shield Plan or the entity chosen by Blue Cross and Blue Shield to administer its prescription drug program, whichever is lower.] 0.35c PDP Wrap

[ELIGIBLE PERSON.....means an employee of the Group who meets the eligibility requirements for this health and/or dental coverage, as described in the ELIGIBILITY SECTION of this Certificate.] 0.43a

[ELIGIBLE PERSON.....means an employee of the Employer Participant who meets the eligibility requirements for this health and/or dental coverage, as described in the ELIGIBILITY SECTION of this Certificate.] 0.43b

[ELIGIBLE PERSON.....means [an employee][or][a retiree] of the Group who meets the eligibility requirements for this coverage, as described in the ELIGIBILITY SECTION of this Certificate.] 0.43c

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

[EMERGENCY MEDICAL CARE.....means services provided for the initial Outpatient treatment, including related Diagnostic Services, of a medical condition displaying itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect that the absence of immediate medical attention could result in:

(i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;

(ii) serious impairment to bodily functions; or

(iii) serious dysfunction of any bodily organ or part.

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

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

Examples of Mental Illness are: major depression with significant suicidal intent, psychosis with associated homicidal intent or a manic episode resulting in inability to care for oneself.] **prior to 1/1/11**

[EMERGENCY MENTAL ILLNESS OR SUBSTANCE ABUSE ADMISSION.....means an admission for the treatment of Mental Illness or Substance Abuse disorders as a result of the sudden and unexpected onset of a Mental Illness or Substance Abuse condition such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect that in the absence of immediate medical treatment would likely result in serious and permanent medical consequences to oneself or others.] **1/1/11 & after**

[EMPLOYER or EMPLOYER PARTICIPANT.....means the company by which you are employed and which is an active member of the Trust.] 0.44

[EMPLOYER HOSPITAL.....means the Hospital that is your employer.] 0.32

[ENROLLMENT DATE.....means 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).]

[EXTENDED MENTAL HEALTH COVERED SERVICES.....means all services and supplies Medically Necessary for the Outpatient treatment of Mental Illness and

Substance Abuse, excluding prescription drugs and any service or supply for the treatment of mental retardation. 0.42

EXTENDED MENTAL HEALTH NETWORK PROVIDER.....means a Provider who has a written agreement, directly or indirectly, with Blue Cross and Blue Shield to provide Extended Mental Health Covered Services to you at the time Covered Services are rendered.] 0.42

[FAMILY COVERAGE.....means coverage for you and your eligible dependents under this Certificate.]

[GROUP POLICY or POLICY.....means the agreement between Blue Cross and Blue Shield and the Group, any addenda, this Certificate, the Benefit Program Application of the Group and the individual applications of the persons covered under the Policy.] 0.45a

[GROUP POLICY or POLICY.....means the agreement between Blue Cross and Blue Shield and the Group, including any addenda that apply to the Policy, as well as the Benefit Program Application of the Group and the individual applications of the persons covered under the Policy.] 0.45aLF

[GROUP POLICY or POLICY.....means the agreement between Blue Cross and Blue Shield and the Trust, any addenda, this Certificate, the applications for Employer participation and the individual applications of the persons covered under the Policy.] 0.45b

[GROUP POLICY or POLICY.....means the agreement between Blue Cross and Blue Shield and the Trust, including any addenda that apply to the Policy, as well as the Benefit Program Application of the Trust, the Employer Participation Agreements and the individual applications of the persons covered under the Policy.] 0.45bLF

[HABILITATIVE SERVICES....means Occupational Therapy, Physical Therapy, Speech Therapy, and other services prescribed by a Physician pursuant to a treatment plan to enhance the ability of a child to function with a Congenital, Genetic, or Early Acquired Disorder.] **New 10/09**

[HOME INFUSION THERAPY PROVIDER.....means a duly licensed home infusion therapy provider.

[A "Participating Home Infusion Therapy Provider" means a Home Infusion Therapy Provider who has a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A "Non-Participating Home Infusion Therapy Provider" means a Home Infusion Therapy Provider who does not have a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.]]

[HOSPICE CARE PROGRAM PROVIDER.....means an organization duly licensed to provide Hospice Care Program Service. 0.33

[A "Participating Hospice Care Program Provider" means a Hospice Care Program Provider which has a written agreement with Blue Cross and Blue Shield to provide services to participants in the [Participating Option][Community Blue] program. 0.33P

A "Non-Participating Hospice Care Program Provider" means a Hospice Care Program Provider which does not have a written agreement with Blue Cross and Blue Shield to provide services to participants in the [Participating Option][Community Blue program.]] 0.33P

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

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

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

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

[A "Participating Hospital" means a Plan Hospital that has an agreement with Blue Cross and Blue Shield of Illinois[or another Blue Cross and/or Blue Shield Plan] to provide Hospital services to participants in [a Participating Provider Option][the Community Blue] program. 0.34 0.3S

A "Non-Participating Hospital" means a Plan Hospital that does not meet the definition of a Participating Hospital.]] 0.34

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

[IN-NETWORK.....means Covered Services rendered or ordered by your Primary Care Physician or another Provider to whom you have been referred by your Primary Care Physician. Your Primary Care Physician has made an agreement with Blue Cross and Blue Shield that referrals will be directed only to [Professional] Providers participating in Blue Cross and Blue Shield's [BlueChoice][point of service] program. However, in the case of treatment of Mental Illness or Substance Abuse Rehabilitation Treatment, In-Network shall mean Covered Services rendered by a Professional Provider to whom you have been referred by Blue Cross and Blue Shield's Mental Health Unit.] 0.46M

[IN-NETWORK.....means a Covered Service is rendered by a Plan Provider which has a written agreement with Blue Cross and Blue Shield of Illinois[or another Blue

Cross and/or Blue Shield Plan] to provide services to participants in a benefit program that utilizes the BlueChoice Select network or a Plan facility or Professional Provider which has been designated by a Blue Cross and/or Blue Shield Plan as a Participating Provider. [However, in the case of treatment of Mental Illness or Substance Abuse Rehabilitation Treatment, In-Network shall mean Covered Services rendered by a Professional Provider to whom you have been referred by Blue Cross and Blue Shield's Mental Health Unit.]] 0.361

[IN-NETWORK.....means a Covered Service is rendered by a Plan Provider which has a written agreement with Blue Cross and Blue Shield of Illinois[or another Blue Cross and/or Blue Shield Plan] or a Plan facility or Professional Provider which has been designated by a Blue Cross and/or Blue Shield Plan to provide services to participants in a benefit program that utilizes the BlueChoice network.]]

[IN-NETWORK.....means Covered Services for the treatment of Mental Illness or Substance Abuse Rehabilitation Treatment rendered or ordered by a Professional Provider to whom you have been referred by the Blue Cross and Blue Shield Mental Health Unit.] 0.361

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

[INTENSIVE OUTPATIENT PROGRAM.....means a freestanding or Hospital-based program that provides services for at least 3 hours per day, 2 or more days per week, to treat Mental Illness or Substance Abuse disorders or specializes in the treatment of co-occurring Mental Illness and Substance Abuse disorders. Dual diagnosis programs offer integrated and aligned assessment, treatment and discharge planning services for treatment of severe or complex co-occurring conditions which make it unlikely that you will benefit from programs that focus solely on Mental Illness conditions. Dual diagnosis programs are delivered by Behavioral Health Practitioners who are cross-trained. **1/1/11 & after**

Intensive Outpatient Program services may be available with less intensity if you are recovering from severe and/or chronic Mental Illness and/or Substance Abuse conditions. If you are recovering from severe and/or chronic Mental Illness and/or Substance Abuse conditions, services may include psychotherapy, pharmacotherapy, and other interventions aimed at supporting recovery such as the development of recovery plans and advance directives, strategies for identifying and managing early warning signs of relapse, development of self-management skills, and the provision of peer support services.

Intensive Outpatient Programs may be used as an initial point of entry into care, as a step up from routine Outpatient services, or as a step down from acute Inpatient, residential care or a Partial Hospitalization Treatment Program.]

[INVESTIGATIONAL or INVESTIGATIONAL SERVICES AND SUPPLIES.....means procedures, drugs, devices, services and/or supplies which (1) are provided or performed in special settings for research purposes or under a controlled environment and which are being studied for safety, efficiency and effectiveness, and/or (2) are awaiting endorsement by the appropriate National Medical Specialty

College or federal government agency for general use by the medical community at the time they are rendered to you, and (3) specifically with regard to drugs, combination of drugs and/or devices, are not finally approved by the Food and Drug Administration at the time used or administered to you.]

[LIMITING CHARGE.....means the maximum charge that Medicare allows a Physician or other provider who is not participating in the Medicare program to charge you for a Covered Service.]

Applicable to Medicare Supplement Plans F & F High Ded. only
36.72

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

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

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

[MANAGED CARE NETWORK PREFERRED ("MCNP").....means the point of service health care benefit program established by Blue Cross and Blue Shield based upon on a network of selected Providers. The MCNP benefit program includes benefit incentives for you to receive Covered Services In-Network.]

0.46M

[MARRIAGE AND FAMILY THERAPIST ("LMFT").....means a duly licensed marriage and family therapist.

[A "Participating Marriage and Family Therapist" means a Marriage and Family Therapist who has a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A "Non-Participating Marriage and Family Therapist" means a Marriage and Family Therapist who does not have a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.]]

[MATERNITY SERVICE.....means the services rendered for normal pregnancy. A normal pregnancy means an intrauterine pregnancy which, through vaginal delivery, results in an infant, who is not premature or preterm. Premature or preterm means an infant born with a low birth weight, 5.5 pounds or less, or an infant born at 37 weeks or less.]

[MAXIMUM ALLOWANCE.....means the amount determined by Blue Cross and Blue Shield, which [MCNP][Participating]Professional Providers have agreed to accept as payment in full for a particular Covered Service. All benefit payments for Covered Services rendered by Professional Providers, whether In-Network or Out-of-Network, will be based on the Schedule of Maximum Allowances[

applicable to BlueChoice]. [Participating][MCNP] Professional Providers have agreed to accept the Maximum Allowance under one of multiple payment tiers to which they are assigned by Blue Cross and Blue Shield from time to time based upon their individual performance [under the [BlueChoice][MCNP] program][in the BlueChoice Select network]. Benefit payment for Out-of-Network Covered Services will be based upon the standard payment tier.[Benefit payments for Covered Services rendered by Professional Providers for the treatment of Mental Illness and/or Substance Abuse Rehabilitation Treatment will be based on the Schedule of Maximum Allowances applicable to Managed Care Mental Health and Substance Abuse Rehabilitation Treatment benefits.] Maximum Allowances may be amended from time to time by Blue Cross and Blue Shield.]

0.361 – POS

[MAXIMUM ALLOWANCE.....means the amount determined by Blue Cross and Blue Shield, which [Community and][Participating]Professional Providers [In-Network] have agreed to accept as payment in full for a particular Covered Service. [All benefit payments for Covered Services rendered by Professional Providers, whether Participating or Non-Participating will be based on the Schedule of Maximum Allowances[applicable to Community Blue].[Benefit payments for Covered Services rendered by Professional Providers for the treatment of Mental Illness and/or Substance Abuse Rehabilitation Treatment will be based on the Schedule of Maximum Allowances applicable to Managed Care Mental Health and Substance Abuse Rehabilitation Treatment Benefits.] These amounts may be amended from time to time by Blue Cross and Blue Shield.]

0.36 **PPO + & CPO – prior to 1/1/11**

[MAXIMUM ALLOWANCE.....means the amount determined by Blue Cross and Blue Shield, which Participating Professional Providers have agreed to accept as payment in full for a particular Covered Service. All benefit payments for Covered Services rendered by Professional Providers, whether In-Network or Out-of-Network, will be based on a Schedule of Maximum Allowances. Benefit payments for Covered Services rendered by BlueChoice network Professional Providers will be based upon the applicable BlueChoice payment tier appropriate for that Provider. Benefit payments for Covered Services rendered by Non-Participating Professional Providers in the PPO or BlueChoice network will be based upon the standard payment tier of the Schedule of Maximum Allowances applicable to BlueChoice. However, benefit payments for Covered Services rendered by Professional Providers in the PPO network, but not in the BlueChoice network, will be based upon the Schedule of Maximum Allowances applicable to the PPO network. Maximum Allowances may be amended from time to time by Blue Cross and Blue Shield.]

BCS

[MAXIMUM ALLOWANCE.....means the amount determined by Blue Cross and Blue Shield, which Participating Dentists have agreed to accept as payment in full for a particular dental Covered Service. All benefit payments for Covered Services rendered by Dentists, whether Participating or Non-Participating will be based on the Schedule of Maximum Allowances. These amounts may be amended from time to time by Blue Cross and Blue Shield.]

0.3DPP

[MAXIMUM ALLOWANCE.....means the amount determined by Blue Cross and Blue Shield, which Participating Dentists have agreed to accept as payment in full for a particular dental Covered Service. All benefit payments for Covered Services

rendered by Participating Dentists will be based on the Schedule of Maximum Allowances. These amounts may be amended from time to time by Blue Cross and Blue Shield.] 0.3DPUC

MAXIMUM ALLOWANCE.....means (a) the amount which Community and Participating Professional Providers have agreed to accept as payment in full for a particular Covered Service. All benefit payments for Covered Services rendered by Community and Participating Professional Providers will be based on the Schedule of Maximum Allowances which these Providers have agreed to accept as payment in full. (b) For Non-Participating Professional Providers, the Maximum Allowance will be the lesser of:

PPO Plus & CPO – 1/1/11 & after

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

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

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

The base Medicare reimbursement rate described above will exclude any Medicare adjustment(s) which is/are based on information on the Claim.

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

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

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

[MCNP PROFESSIONAL PROVIDERS.....means 1) your Primary Care Physician and 2) Professional Providers when Covered Services are rendered In-Network.] 0.46M

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

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

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

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

[MEDICARE ELIGIBLE EXPENSES.....means expenses of the kinds covered by Medicare Parts A and B to the extent recognized as reasonable and medically necessary by Medicare.]

Applicable to Medicare Supplement only

[MEDICARE SECONDARY PAYER or MSP.....means those provisions of the Social Security Act set forth in 42 U.S.C. §1395 y (b), and the implemented 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 HEALTH UNIT.....means a unit established to perform preadmission review and length of stay review for Inpatient services and/or review of Outpatient services for the treatment of Mental Illness and Substance Abuse.]

prior to 1/1/11

[MENTAL HEALTH UNIT.....means a unit established to assist in the administration of Mental Illness and Substance Abuse Rehabilitation Treatment benefits including Preauthorization, Emergency Mental Illness or Substance Abuse Admission Review and length of stay/service review for Inpatient Hospital admissions[and/or review of Outpatient services] for the treatment of Mental Illness and Substance Abuse disorders.]

1/1/11 & after

[MENTAL ILLNESS.....means those illnesses classified as disorders in the current *Diagnostic and Statistical Manual of Mental Disorders* published by the American Psychiatric Association.

"Serious Mental Illness".....means the following mental disorders as classified in the current *Diagnostic and Statistical Manual* published by the American Psychiatric Association:

(i) Schizophrenia;

(ii) Paranoid and other psychotic disorders;

(iii) Bipolar disorders (hypomanic, manic, depressive and mixed);

(iv) Major depressive disorders (single episode or recurrent);

(v) Schizoaffective disorders (bipolar or depressive);

(vi) Pervasive developmental disorders;

(vii) Obsessive-compulsive disorders;

(viii) Depression in childhood and adolescence;

(ix) Panic disorder;

(x) Post-traumatic stress disorders (acute, chronic, or with delayed onset); and

(xi) Anorexia nervosa and bulimia nervosa.]

[NAPRAPATH.....means a duly licensed naprapath.

NAPRAPATHIC SERVICES.....means the performance of naprapathic practice by a Naprapath which may legally be rendered by them.]

[NON-PARTICIPATING DENTIST.....SEE DEFINITION OF DENTIST.] 0.3DP

[NON-PARTICIPATING HOSPITAL.....SEE DEFINITION OF HOSPITAL.] 0.34

[NON-PARTICIPATING PROFESSIONAL PROVIDER.....SEE DEFINITION OF PROVIDER.]

[NON-PARTICIPATING PROVIDER.....SEE DEFINITION OF PROVIDER.] 0.34

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

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

[OCCUPATIONAL THERAPIST.....means a duly licensed occupational therapist.]

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

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

[A "Participating Optometrist" means an Optometrist who has a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A "Non-Participating Optometrist" means an Optometrist who does not have a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.]]

[ORTHOTIC PROVIDER.....means a duly licensed orthotic provider.

[A "Participating Orthotic Provider" means an Orthotic Provider who has a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A "Non-Participating Orthotic Provider" means an Orthotic Provider who does not have a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.]]

[OUT-OF-NETWORK.....means (a) Covered Services not rendered or ordered by your [MCNP]Primary Care Physician or upon referral of your Primary Care Physician or (b) in the case of Covered Services rendered for the treatment of Mental Illness or Substance Abuse Rehabilitation Treatment, Covered Services rendered by a Professional Provider to whom you have not been referred by the Blue Cross and Blue Shield Mental Health Unit.] 0.46M

[OUT-OF-NETWORK.....means Covered Services rendered by a Plan Provider which does not have a written agreement with Blue Cross and Blue Shield of Illinois to provide services to participants in a benefit program that utilizes the BlueChoice Select network. For purposes of the provision of this Certificate entitled "WARNING, LIMITED BENEFITS WILL BE PAID WHEN NON-PARTICIPATING PROVIDERS ARE USED," a Non-Participating Provider means a Professional Provider who renders Out-of-Network Covered Services.[However, in the case of treatment of Mental Illness or Substance Abuse Rehabilitation Treatment, Out-of-Network shall mean Covered Services rendered or ordered by a Provider to whom you have not been referred by Blue Cross and Blue Shield's Mental Health Unit.]]

[OUT-OF-NETWORK.....means a Covered Service is rendered by a Plan Provider which does not have a written agreement with Blue Cross and Blue Shield of Illinois to provide services to participants in a benefit program that utilizes the BlueChoice network.]

[OUT-OF-NETWORK.....means Covered Services for the treatment of Mental Illness or Substance Abuse Rehabilitation Treatment rendered or ordered by a Professional Provider to whom you have not been referred by the Blue Cross and Blue Shield Mental Health Unit.] 0.361

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

[PARTIAL HOSPITALIZATION TREATMENT PROGRAM.....means a Blue Cross and Blue Shield approved planned program of a Hospital or Substance Abuse Treatment Facility for the treatment of Mental Illness or Substance Abuse Rehabilitation Treatment in which patients spend days or nights[, for less than a 24 hour period].]

[PARTICIPATING DENTIST.....SEE DEFINITION OF DENTIST.] 0.3DP

[PARTICIPATING PRESCRIPTION DRUG PROVIDER.....SEE DEFINITION OF PROVIDER.]

[PARTICIPATING PROFESSIONAL PROVIDER.....SEE DEFINITION OF PROVIDER.]

[PARTICIPATING PROVIDER.....SEE DEFINITION OF PROVIDER.]

[PARTICIPATING PROVIDER OPTION.....means a program of [health][dental] care benefits designed to provide you with economic incentives for using designated Providers of [health][dental] care services.] 0.34

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

[PHYSICAL THERAPIST.....means a duly licensed physical therapist.]

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

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

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

[PLAN HOSPITAL.....SEE DEFINITION OF HOSPITAL.]

[PLAN PROVIDER.....SEE DEFINITION OF PROVIDER.]

[PODIATRIST.....means a duly licensed podiatrist.]

[PREAUTHORIZATION, PREAUTHORIZE or EMERGENCY MENTAL ILLNESS OR SUBSTANCE ABUSE ADMISSION REVIEW.....means a submission of a request to the Mental Health Unit for a determination of Medically Necessary care under this Certificate.] **1/1/11 & after**

[PREEXISTING CONDITION.....means any disease, illness, sickness, malady or condition for which medical advice, diagnosis, care or treatment was received or recommended by a Provider within [3–6]6 months prior to your Enrollment Date. Taking prescription drugs is considered medical treatment even if your condition was diagnosed more than [3–6]6 months before your Enrollment Date. For purposes of this definition, pregnancy or conditions based solely on genetic information are not preexisting conditions.]

[PRIMARY CARE PHYSICIAN ("PCP").....means a Physician who practices in one of the following: a) Internal Medicine; b) Family Practice; c) Pediatrics; or d) Obstetrics/Gynecology and has entered into a Primary Physician Care-Giver Agreement with Blue Cross and Blue Shield[to participate in the BlueChoice program]. Primary Care Physicians have agreed to be your principal care-giver and to render care to meet your medical needs within your Primary Care Physician's competence.

Your Primary Care Physician has agreed to use Providers participating in the [BlueChoice][point of service] program for all care required by you. When referrals are necessary, your Primary Care Physician has agreed to authorize, coordinate and monitor all of your specialty and/or institutional care referrals and to maintain referrals within Blue Cross and Blue Shield's [BlueChoice][point of service] network.] 0.46M

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

[PROFESSIONAL PROVIDER.....SEE DEFINITION OF PROVIDER.] 0.39

[PROSTHETIC PROVIDER.....means a duly licensed prosthetic provider.

[A "Participating Prosthetic Provider" means a Prosthetic Provider who has a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A "Non-Participating Prosthetic Provider" means a Prosthetic Provider who does not have a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.]]

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

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

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

[A "Participating Provider" means a Plan Hospital[, Plan facility] or Professional Provider which has a written agreement with Blue Cross and Blue Shield of Illinois[or another Blue Cross and/or Blue Shield Plan] to provide services to participants in[the Community Blue][a Participating Provider Option][a BlueChoice]] program[utilizing the BlueChoice network][or a Plan facility or Professional Provider which has been designated by a Blue Cross and/or Blue Shield Plan as a Participating Provider]. 0.38 0.381 0.3S

A "Non-Participating Provider" means a Plan Hospital[, Plan facility] or Professional Provider which does not have a written agreement with Blue Cross and Blue Shield of Illinois[or another Blue Cross and/or Blue Shield Plan] to provide services to participants in[the Community Blue][a Participating Provider Option] program[or a facility which has not been designated by Blue Cross and Blue Shield of Illinois as a Participating Provider].] 0.37 0.371 0.3S

[A "Community Provider" means a Participating Hospital[or a Professional Provider] that has been designated by Blue Cross and Blue Shield to provide services to participants in the Community Participating Option program.]

[A “Professional Provider” means a Physician, Dentist, Podiatrist, Psychologist, Chiropractor, Optometrist, Clinical Social Worker or any Provider designated by Blue Cross and Blue Shield of Illinois[or another Blue Cross and/or Blue Shield Plan].] 0.39 0.3S

[A “Participating Professional Provider” means a Professional Provider who has a written agreement with Blue Cross and Blue Shield of Illinois[or another Blue Cross and/or Blue Shield Plan] to provide services to participants in a Participating Provider Option program or a Professional Provider who has been designated by a Blue Cross and/or Blue Shield Plan as a Participating Professional Provider.]

[A “Non-Participating Professional Provider” means a Professional Provider who does not have a written agreement with Blue Cross and Blue Shield of Illinois[or another Blue Cross and Blue Shield Plan or Blue Cross Plan] to provide services to participants in a Participating Provider Option program. For purposes of the provision of this Certificate entitled “WARNING, LIMITED BENEFITS WILL BE PAID WHEN NON-PARTICIPATING PROVIDERS ARE USED,” a Non-Participating Provider means a Non-Participating Professional Provider.]

[A “Participating Prescription Drug Provider” means a Pharmacy that has a written agreement with a Blue Cross and/or Blue Shield Plan or the entity chosen by Blue Cross and Blue Shield to administer its prescription drug program to provide services to you at the time you receive the services.]]

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

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

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

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

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

[REGISTERED SURGICAL ASSISTANT.....means a duly licensed certified surgical assistant, certified surgical technician, surgical assistant certified or registered nurse first assistant.

[A “Participating Registered Surgical Assistant” means a Registered Surgical Assistant who has a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and Blue Shield Plan or Blue Cross Plan to provide services to you at the time services are rendered.

A "Non-Participating Registered Surgical Assistant" means a Registered Surgical Assistant who does not have a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and Blue Shield Plan or Blue Cross Plan to provide services to you at the time services are rendered.]]

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

[RESIDENTIAL TREATMENT CENTER.....means a facility setting offering therapeutic intervention and special programming in a controlled environment which also offers a degree of security, supervision and structure. Patients are medically monitored with 24 hour medical availability and 24 hour onsite nursing service for patients with Mental Illness and/or Substance Abuse disorders.] **1/1/11 & after**

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

[RETAIL HEALTH CLINIC.....means a health care clinic located in a retail setting, supermarket or Pharmacy which provides treatment of common illnesses and routine preventive health care services by Certified Nurse Practitioners.

[A "Participating Retail Health Clinic" means a Retail Health Clinic who has a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and Blue Shield Plan or Blue Cross Plan to provide services to you at the time services are rendered.

A "Non-Participating Retail Health Clinic" means a Retail Health Clinic who does not have a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and Blue Shield Plan or Blue Cross Plan to provide services to you at the time services are rendered.]]

[SERIOUS MENTAL ILLNESS.....SEE DEFINITION OF MENTAL ILLNESS.]

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

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

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

[A "Participating Skilled Nursing Facility" means a Plan Skilled Nursing Facility which has a written agreement with Blue Cross and Blue Shield to provide services to participants in the[Participating Option][Community Blue] program. 0.3P

A "Non-Participating Skilled Nursing Facility" means a Plan Skilled Nursing Facility which does not have a written agreement with Blue Cross and Blue Shield to provide services to participants in the[Participating Option][Community Blue] program.]

0.3P

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

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

[SPEECH THERAPIST.....means a duly licensed speech therapist.]

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

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

prior to 7/1/10 or MHP does not apply

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

MHP Final regs – 7/1/10 & after

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

prior to 7/1/10 or MHP does not apply

[SUBSTANCE ABUSE REHABILITATION TREATMENT.....means an organized, intensive, structured, rehabilitative treatment program of either a Hospital or Sub-

stance Abuse Treatment Facility. It does not include programs consisting primarily of counseling by individuals (other than a Behavioral Health Practitioner), 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.]

MHP Final regs – 7/1/10 & after

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

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

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

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

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

[TOTALLY DISABLED.....means with respect to an Eligible Person, an inability by reason of illness, injury or physical condition to perform the material duties of any occupation for which the Eligible Person is or becomes qualified by reason of experience, education or training or with respect to a covered person other than an Eligible Person, the inability 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.]

[USUAL AND CUSTOMARY FEE.....means the fee as reasonably determined by Blue Cross and Blue Shield, which is based on the fee which the Physician[,] [or]Dentist[, Podiatrist, Psychologist, Clinical Social Worker, Chiropractor or Optometrist] who renders the particular services usually charges his patients for the same service and the fee which is within the range of usual fees other Physicians[,] [or]Dentists[, Podiatrists, Psychologists, Clinical Social Workers, Chiropractors or Optometrists] of similar training and experience in a similar geographic area charge their patients for the same service, under similar or comparable circumstances. However, if Blue Cross and Blue Shield reasonably determines that the Usual and Customary Fee for a particular service is unreasonable because of extenuating or unusual circumstances, the Usual and Customary Fee for such service shall mean the reasonable fee as reasonably determined by Blue Cross and Blue Shield but in no event shall the reasonable fee be less than the Usual and Customary Fee.]

Base +, CMM & PPO Hospital Only, – prior to 1/1/11 & all Dental

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

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

The base Medicare reimbursement rate described above will exclude any Medicare adjustment(s) which is/are based on information on the Claim.

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

Base +, CMM & PPO Hospital Only, 1/1/11 & after

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

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

ELIGIBILITY SECTION

This Certificate contains information about the [health care][dental care] benefit program for the persons in your Group who:

- [Meet the definition of an Eligible Person as specified in the Group Policy;] 0.511a
- Meet the following definition of an Eligible Person: [A full-time employee of the Group. A full-time employee is a person who is scheduled to work a minimum of [20–60] hours per week and who is on the permanent payroll of the Group][]; 0.511b 0.511b1 0.511b2
- [Live within Blue Cross and Blue Shield of Illinois' service area;]
- Have applied for this coverage; and
- Have received a Blue Cross and Blue Shield [dental]ID card.

If you meet this description of an Eligible Person, you are entitled to the benefits of this program.

[Replacement of Discontinued Group Coverage

When your Group initially purchases this coverage and such coverage is purchased as replacement of coverage under another carrier's group policy, those persons who are Totally Disabled on the effective date of this Policy and were covered under the prior group policy will be considered Eligible Persons under this Certificate.

Your Totally Disabled dependents will be considered eligible dependents under this Certificate if such dependents meet the description of an eligible family member as specified in the Eligibility Section of this Certificate.

Your 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 dependent upon you or other care providers for lifetime care and supervision.

If you are Totally Disabled, you will be entitled to all of the benefits described in this Certificate. The benefits of this Certificate will be coordinated with the benefits under your prior group policy. Your prior group policy will be considered the primary coverage for all services rendered in connection with your disabling condition when no coverage is available under this Certificate whether due to absence of coverage in this Certificate or lack of required Creditable Coverage for a preexisting condition.]

[YOUR APPLICATION FOR COVERAGE

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

liable for any claim payment amounts greater than the total amount of premiums paid during the period for which cancellation is effected.] 0.51a

[**MEDICARE ELIGIBLE COVERED PERSONS**

If you meet the definition of an Eligible Person stated in the Eligibility Section above and you are eligible for Medicare and not affected by the ''Medicare Secondary Payer'' (MSP) laws as described below, the benefits described in this Certificate apply to you and to your spouse and covered dependent children (if he or she is also eligible for Medicare and not affected by the MSP laws). Your benefit payments under this Certificate will be determined according to the rules described in the Coordination of Benefits Section of this Certificate.

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.] 0.52

PLEASE NOTE: SEE YOUR EMPLOYER OR GROUP ADMINISTRATOR SHOULD YOU HAVE ANY QUESTIONS REGARDING THE ESRD PRIMARY PERIOD OR OTHER PROVISIONS OF MSP LAWS AND THEIR APPLICATION TO YOU, YOUR SPOUSE OR ANY 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

Blue Cross and Blue Shield 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 BLUE CROSS AND BLUE SHIELD ID CARD

You will receive a Blue Cross and Blue Shield[identification card.][dental identification card. This may be in addition to your Blue Cross and Blue Shield identification card, if applicable.] This card will tell you your Blue Cross and Blue Shield[dental] identification number and will be very important to you in obtaining your benefits.

INDIVIDUAL COVERAGE

If you have Individual Coverage, only your own expenses for Covered Services are covered, not the expenses of other members of your family.

[FAMILY COVERAGE

[If you have Family Coverage, your expenses for Covered Services and those of your enrolled spouse and your (or your spouse's) enrolled unmarried children who are under age [26–30] will be covered. Enrolled unmarried children who are full-time students will be covered up to age [26–30]. 0.531a

[Coverage will continue under the Certificate for an unmarried dependent who is unable to maintain full-time student status as a result of a medically necessary leave of absence or any other change in enrollment, provided that:][

- The dependent is enrolled under the Certificate on the basis of being a student at a postsecondary educational institution; and][
- The dependent was covered immediately before the first day of the medically necessary leave of absence or other change in enrollment; and][
- The dependent child's treating Physician provides to Blue Cross and Blue Shield a written certification stating that the child is suffering from a serious illness or injury and that the leave of absence or other change in enrollment is medically necessary.][

[Coverage for such a dependent may be continued under the Certificate until the date that is the earlier of:

- One year after the first day of the medically necessary leave of absence or other change in enrollment; or][
- The date on which such coverage would otherwise terminate under the terms of the Certificate.][

[The first day of the medically necessary leave of absence will be documented as the date indicated by the physician in the written certification on which the medical leave or other enrollment change is to begin.][

[If you have Family Coverage, your expenses for Covered Services and those of your enrolled spouse and your (or your spouse's) enrolled unmarried children who are under age [26–30] will be covered.] 0.531b

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

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

[Coverage for unmarried children will end on the last day of the calendar month in which the limiting age birthday falls.] 0.5312a

[Coverage for unmarried children will end on the last day of the calendar year in which the limiting age birthday falls.] 0.5313a

[If your child becomes ineligible, his or her coverage will end on the last day of the period for which premium has been accepted.] 0.5314a

[Your enrolled Domestic Partner and his or her enrolled unmarried children who have not attained the limiting age stated above will be covered. Whenever the term "spouse" is used, we also mean Domestic Partner. All of the provisions of this Certificate that pertain to a spouse also apply to a Domestic Partner, unless specifically noted otherwise.] **Revised** 0.532

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

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 if they were covered prior to reaching the limiting age stated above.

Any children who are under your legal guardianship or who are in your custody under an interim court order of adoption or who are placed with you for adoption vesting temporary care will be covered.

This coverage does not include benefits for grandchildren (unless such children are under your legal guardianship) or foster children.] 0.53

[CHANGING FROM INDIVIDUAL TO FAMILY COVERAGE OR ADDING DEPENDENTS TO 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.
- [Establishment of a Domestic Partnership.] 0.532
- Birth, adoption or placement for adoption of a child.
- Obtaining legal guardianship of a child.

- 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 making 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 of an employee, termination of employment, or reduction in the number of hours of employment;
  b. In the case of HMO coverage, coverage is no longer provided because an individual no longer resides in the service area or the HMO no longer offers coverage in the HMO service area in which the individual resides;
  c. Reaching a lifetime limit on all benefits in another group health plan;
  d. Another group health plan no longer offering any benefits to the class of similarly situated individuals that includes you or your dependent;
  e. When Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility; or
  f. When you or your dependents become eligible for a premium assistance subsidy under Medicaid or CHIP.
- 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 dependents 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.
- [Establishment of a Domestic Partnership.] 0.532
- Birth, adoption, or placement of adoption of a child.
- Obtaining legal guardianship of a child.

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 dependents 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 coverage 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. 0.54

Your Family Coverage or the coverage for your additional dependents will be effective no later than the first of the month after the special enrollment request is received if you apply within 60 days of any of the following events:

- Loss of eligibility for you or your dependents when Medicaid or CHIP coverage is terminated as a result of loss of eligibility; or
- You or your dependents become eligible for a premium assistance subsidy under Medicaid or CHIP. 0.5

You must request this special enrollment within 60 days of the loss of Medicaid or CHIP coverage, or within 60 days of when eligibility for premium assistance under Medicaid or CHIP is determined. Coverage will be effective no later then the first of the month after the special enrollment request is received. 0.5

Late Applicants

[If you do not apply for Family Coverage or to add dependents within the required number of days of the event, you can apply at any time to make those changes.[Your dependents will then be subject to the[[180–546] days] Preexisting Condition waiting period as described in the Preexisting Condition Waiting Period provision of this benefit section.] Such changes will be effective on a date that has been mutually agreed to by your Group and Blue Cross and Blue Shield.] 0.5611a

[If you do not apply for Family Coverage or to add dependents within the required number of days of the event, you will have to wait until your Group's annual open enrollment period to make those changes.[Your dependents will then be subject to the[[180–546] days] Preexisting Condition waiting period as described in the Preexisting Condition Waiting Period provision of this benefit section.] Such changes will be effective on a date that has been mutually agreed to by your Group and Blue Cross and Blue Shield.] 0.5611b

[If you do not apply for Family Coverage within the required number of days of the event, you can apply at any time or you can wait until your Group's annual open enrollment to make those changes.[Your dependents will then be subject to the[[180–546] days] Preexisting Condition waiting period as described in the

Preexisting Condition Waiting Period provision of this benefit section.] Such changes will be effective on a date that has been mutually agreed to by your Group and Blue Cross and Blue Shield.]] 0.5611c

[CHANGING FROM FAMILY TO INDIVIDUAL COVERAGE

Should you wish to change from Family to Individual Coverage, you may do this at any time. Your Group Administrator will provide you with the application and tell you the date that the change will be effective.[Premiums will be adjusted accordingly.]] 0.542 0.5421

[Should you wish to change from Family to Individual Coverage, contact your Group Administrator.]] **New Code 9/09**

[PREEXISTING CONDITION WAITING PERIOD

Your benefits (other than for Maternity Services) are subject to a Preexisting Condition waiting period of [90–365] days. The Preexisting Condition waiting period will begin on the Enrollment Date for you and your eligible dependents (if Family Coverage is effective) and will continue for the number of days specified. This Preexisting Condition waiting period will also apply to each dependent (other than a newborn child, an adopted child under age 18, a child under age 18 placed for adoption or a child under your legal guardianship if the child is enrolled within 31 days of birth, adoption, placement for adoption or legal guardianship) for whom coverage is applied for after your Coverage Date. The Preexisting Condition waiting period for such a dependent will begin on the dependent's Enrollment Date.

[However, benefits for those persons who do not apply for coverage when first eligible to do so are subject to a Preexisting Condition waiting period of [180–546] days.] 0.56a

If you had health coverage prior to getting this coverage without a break in coverage of 63 days or more, your Preexisting Condition waiting period is reduced by the length of time you had Creditable Coverage. You have the right to request a Certificate of Creditable Coverage from any previous health plan or insurer. Blue Cross and Blue Shield will assist you in obtaining the Certificate of Creditable Coverage, if needed.] 0.56

[Benefits for those persons who become members of the Group after the effective date of the Group Policy will be limited to a maximum of $[500–60,000] for Covered Services rendered in connection with a Preexisting Condition during the Preexisting Condition waiting period, if applicable.] 0.563b

[This Preexisting Condition waiting period does not apply to those persons who were members of the Group and applied for coverage at the time that the Group initially purchased this coverage.] 0.561a

[This Preexisting Condition waiting period does not apply to those persons who were members of the Group and applied for coverage at the time that the Group initially purchased health insurance from Blue Cross and Blue Shield. However, this Preexisting Condition waiting period will be waived only if the member had health insurance with the Group immediately prior to the date the Group initially

purchased health insurance from Blue Cross and Blue Shield or had 63 days of Creditable Coverage.

You should be aware that the date your group initially purchased health insurance from Blue Cross and Blue Shield may be different than the date your Group purchased the particular coverage described in this Certificate.] 0.561b

[However, benefits for initial enrollees will be limited to a maximum of $[500–60,000] for Covered Services rendered in connection with a Preexisting Condition during the first 365 days of coverage.] 0.563a

[The Preexisting Condition waiting period does not apply to the following benefit section(s) of this Certificate: [Outpatient Prescription Drug Program Benefit Section, Vision Care Program, Hearing Care Program, and Dental Benefit Section].] 0.562

[DENTAL BENEFIT WAITING PERIOD 0.566

[Certain dental benefits under this benefit program may be subject to a Benefit Waiting Period. You will not be eligible for benefits for these Covered Services during your Benefit Waiting Period. If your dental benefit program has a Benefit Waiting Period, it is listed in your Benefit Highlights (an insert) of this Certificate. Your Benefit Waiting Period will begin on your Coverage Date and will continue for the number of months specified.] 0.566G

[Certain dental benefits under this benefit program are subject to a Benefit Waiting Period. You will not be eligible for benefits for these Covered Services for the number of months specified below: 0.566a

- [General Dental Services — [1–24] month(s)] 0.566a1
- [Endodontic Services — [1–24] month(s)] 0.566a2
- [Periodontic Services —[1–24] month(s)] 0.566a3
- [Oral Surgery Services —[1–24] month(s)] 0.566a4
- [Crowns, Inlays/Onlays Services —[1–24] month(s)] 0.566a5
- [Prosthodontic Services — [1–24] month(s)] 0.566a6
- [Implants — [1–24] month(s)] 0.566a7
- [Orthodontic Dental Services —[1–24] month(s)] 0.566a8
- [Temporomandibular Joint Services —[1–24] month(s)] 0.566a9

Your Benefit Waiting Period will begin on your Coverage Date and will continue for the number of months specified.] 0.566a

[This Benefit Waiting Period does not apply to those persons who were members of the Group and applied for coverage at the time that the Group initially purchased this coverage.]] 0.566b

TERMINATION OF COVERAGE

You will no longer be entitled to the benefits described in this Certificate if either of the events stated below should occur.

1. If you no longer meet the previously stated description of an Eligible Person.
2. If the entire coverage of your Group terminates.

Termination of the Group Policy automatically terminates your coverage under this Certificate. It is the responsibility of your Group to notify you of the termination of the Group Policy, but your coverage will automatically terminate as of the effective date of termination of the Group Policy regardless of whether such notice is given.

No benefits are available to you for services or supplies rendered after the date of termination of your coverage under this Certificate except as otherwise specifically stated in the ''Extension of Benefits in Case of Termination'' provision[s] of this Certificate[or as specified below when your entire Group's coverage terminates]. However, termination of the Group Policy and/or your coverage under this Certificate shall not affect any Claim for Covered Services rendered prior to the effective date of such termination.

[Unless specifically mentioned elsewhere in this Certificate, if one of your dependents becomes ineligible, his or her coverage will end as of the date the event occurs which makes him or her ineligible (for example, date of marriage, date of divorce, date the limiting age is reached).] 0.57

Upon the death of an Eligible Person, dependents under his or her family coverage will have the option to continue coverage for a period of 90 days subject to any other Certificate provisions relating to termination of such person's coverage, provided such person makes payment for coverage.

Other options available for continuation of coverage are explained in the Continuation of Coverage After Termination Sections of this Certificate.

[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.] 0.571

[Extension of Benefits In Case of Discontinuance

[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. It is your responsibility to notify Blue Cross and Blue Shield, and to provide, when requested by Blue Cross and Blue Shield, written documentation of such disability.[This extension of benefits will not apply to the following benefit section(s) of this Certificate: [Outpatient Prescription Drug Program Benefit Section, Vision Care Program, Hearing Care Program, and Dental Benefit Section].]] 0.591 0.59

[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 Covered Services described in the Hospital and Physician Benefit Sections for a period of no more than 90 days from the date of termination or for Covered Services described in the Major Medical Benefit Section for a period of no more than 12 months from the date of termination. It is your responsibility to notify Blue Cross and Blue Shield, and to provide, when requested by Blue Cross and Blue Shield, written documentation of such disability.[This extension of benefits will not apply to the following benefit section(s) of this Certificate: [Outpatient Prescription Drug Program Benefit Section, Vision Care Program, Hearing Care Program, and Dental Benefit Section].]] 0.591 0.59

[**CONVERSION PRIVILEGE**

If your coverage under this Certificate should terminate and you want to continue Blue Cross and Blue Shield coverage with no interruption, you may do so if you have been insured under this coverage for at least 3 months and your Group has not cancelled this coverage and replaced it with other coverage. Here is what to do:

1. Tell Blue Cross and Blue Shield or your Group Administrator that you wish to continue your coverage and you will be provided with the necessary application.
2. Send the application and first premium to Blue Cross and Blue Shield within 31 days of the date you leave your Group or within 15 days after you have been given written notice of the conversion privilege, but in no event later than 60 days after you leave your Group.

Having done so, you will then be covered by Blue Cross and Blue Shield on an individual "direct pay" basis. This coverage will be effective from the date your Group coverage terminates so long as the premiums charged for the direct pay coverage are paid when due.

These direct pay benefits (and the premium charged for them) may not be exactly the same as the benefits under this Certificate. However, by converting your coverage, your health care benefits are not interrupted and you will not have to repeat waiting periods (if any).

[Should any or all of your dependents become ineligible for coverage under this Certificate, they may convert to direct pay coverage by following the instructions stated above.]] 0.58

ELIGIBILITY SECTION

This Certificate contains information about the benefit program for the persons in your Group who:[

- are eligible for Medicare Part A and Part B;][**Revised**
- are enrolled in a Medicare Part D Prescription Drug Plan;] **New**
- are not affected by the ‘‘Medicare Secondary Payer’’ (MSP) laws as described below; and
- meet the definition of an Eligible Person as specified in the Group Policy.

If you meet this description of an Eligible Person, have applied for this coverage and have received a Blue Cross and Blue Shield ID card, then you are entitled to the benefits of this program.

[Replacement of Discontinued Group Coverage

When your Group initially purchases this coverage and such coverage is purchased as replacement of coverage under another carrier’s group policy, those persons who are Totally Disabled on the effective date of this Policy and were covered under the prior group policy will be considered Eligible Persons under this Certificate.

Your Totally Disabled dependents will be considered eligible dependents under this Certificate if such dependents meet the description of an eligible family member as specified in the Eligibility Section of this Certificate.

Your 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 dependent upon you or other care providers for lifetime care and supervision.

If you are Totally Disabled, you will be entitled to all of the benefits described in this Certificate. The benefits of this Certificate will be coordinated with the benefits under your prior group policy. Your prior group policy will be considered the primary coverage for all services rendered in connection with your disabling condition when no coverage is available under this Certificate whether due to absence of coverage in this Certificate or lack of required Creditable Coverage for a preexisting condition.] 37.5

[MEDICARE SECONDARY PAYER (“MSP”) LAWS

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.] 37.1

PLEASE NOTE: SEE YOUR EMPLOYER OR GROUP ADMINISTRATOR SHOULD YOU HAVE ANY QUESTIONS REGARDING THE ESRD PRIMARY PERIOD OR OTHER PROVISIONS OF MSP LAWS AND THEIR APPLICATION TO YOU, YOUR SPOUSE OR ANY 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 Blue Cross and Blue Shield 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 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.] **Revised**

YOUR BLUE CROSS AND BLUE SHIELD ID CARD

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

INDIVIDUAL COVERAGE

If you have Individual Coverage, only your own expenses for Covered Services are covered, not the expenses of other members of your family.

[FAMILY COVERAGE

[Your spouse [is][and your (or your spouse's) unmarried children are] also eligible for coverage under this Certificate if eligible for Medicare Part A and Part B.] **Revised**

[Your spouse [is][and your (or your spouse's) unmarried children are] also eligible for coverage under this Certificate if enrolled in a Medicare Part D Prescription Drug Plan.] **New**

[If you have Family Coverage, your expenses for Covered Services and those of your enrolled spouse [and your (or your spouse's) enrolled unmarried children who are under age [19–30]] will be covered.][Enrolled unmarried children who are full-time students will be covered up to age [19–30]. The coverage for unmarried children will end [on the birthday.][on the last day of the month in which the limiting age is reached.][on the last day of the calendar year in which the limiting age is reached.]] 37.21a, 37.21a1, 37.21a2, 37.21a3

[If you have Family Coverage, your expenses for Covered Services and those of your enrolled spouse [and your (or your spouse's) enrolled unmarried children who are under age [19–30]]will be covered.][The coverage for unmarried children will end [on the birthday.][on the last day of the month in which the limiting age is reached.][on the last day of the calendar year in which the limiting age is reached.]] 37.21b, 37.21b1, 37.21b2, 37.21b3

[Your enrolled Domestic Partner[and his or her enrolled unmarried children who have not attained the limiting age stated above] will be covered if eligible for Medicare Part A and Part B. Whenever the term "spouse" is used, we also mean Domestic Partner. All of the provisions of this Certificate that pertain to a spouse also apply to a Domestic Partner.] 37.23 **Revised**

[Your enrolled Domestic Partner[and his or her enrolled unmarried children who have not attained the limiting age stated above] will be covered if enrolled in a Medicare Part D Prescription Drug Plan. Whenever the term "spouse" is used, we also mean Domestic Partner. All of the provisions of this Certificate that pertain to a spouse also apply to a Domestic Partner.] 37.23 **New**

[Any newborn children will be covered from the moment of birth. Please notify your Group Administrator within 31 days of the date of birth so that your membership records can be adjusted.]

[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 if they were covered prior to reaching the limiting age stated above.]

[Any children who are under your legal guardianship or who are in your custody under an interim court order of adoption or who are placed with you for adoption vesting temporary care will be covered.]

[This coverage does not include benefits for grandchildren (unless such children are under your legal guardianship) or foster children.] 37.2

[CHANGING FROM INDIVIDUAL TO FAMILY COVERAGE OR ADDING DEPENDENTS TO 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.
- [Establishment of a Domestic Partnership.] 37.23
- Birth, adoption or placement for adoption of a child.
- Obtaining legal guardianship of a child.
- [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 making 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 the number of hours of employment;

b. In the case of HMO coverage, 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 dependents 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.
- [Establishment of a Domestic Partnership.] 37.23
- Birth, adoption, or placement of adoption of a child.
- Obtaining legal guardianship of a child.

[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 dependents 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 coverage 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.] 37.2

Late Applicants 37.24

[If you do not apply for Family Coverage or to add dependents within 31 days of the event, you can apply at any time to make those changes.[Your dependents will then be subject to the[[180–546] days] Preexisting Condition waiting period as described in the Preexisting Condition Waiting Period provision of this benefit section.] Such changes will be effective on a date that has been mutually agreed to by your Group and Blue Cross and Blue Shield.] 37.24a

[If you do not apply for Family Coverage or to add dependents within 31 days of the event, you will have to wait until your Group's annual open enrollment period to make those changes.[Your dependents will then be subject to the[[180–546] days] Preexisting Condition waiting period as described in the Preexisting Condition Waiting Period provision of this benefit section.] Such changes will be effective on a date that has been mutually agreed to by your Group and Blue Cross and Blue Shield.] 37.24b

[If you do not apply for Family Coverage within 31 days of the event, you can apply at any time or you can wait until your Group's annual open enrollment to make those changes.[Your dependents will then be subject to the[[180–546] days] Preexisting Condition waiting period as described in the Preexisting Condition Waiting Period provision of this benefit section.] Such changes will be effective on a date that has been mutually agreed to by your Group and Blue Cross and Blue Shield.]] 37.24c

[CHANGING FROM FAMILY TO INDIVIDUAL COVERAGE

Should you wish to change from Family to Individual Coverage, you may do this at any time. Your Group Administrator will provide you with the application and tell you the date that the change will be effective.[Premiums will be adjusted accordingly.]] 37.2 code

[PREEXISTING CONDITION WAITING PERIOD

Your benefits (other than for Maternity Services) are subject to a Preexisting Condition waiting period of [90–365] days. The Preexisting Condition waiting period will begin on the Enrollment Date[for you and your eligible dependents (if Family Coverage is effective)] and will continue for the number of days specified.[This Preexisting Condition waiting period will also apply to each dependent [(other than a newborn child, an adopted child under age 18, a child under age 18 placed for adoption or a child under your legal guardianship if the child is enrolled within 31 days of birth, adoption, placement for adoption or legal guardianship)]for whom coverage is applied for after your Coverage Date. The Preexisting Condition waiting period for such a dependent will begin on the dependent's Enrollment Date.]

[However, benefits for those persons who do not apply for coverage when first eligible to do so are subject to a Preexisting Condition waiting period of [180–546] days.] 37.3a

[If you had health coverage prior to getting this coverage without a break in coverage of 63 days or more, your Preexisting Condition waiting period is reduced by the length of time you had Creditable Coverage. You have the right to request a Certificate of Creditable Coverage from any previous health plan or insurer. Blue Cross and

Blue Shield will assist you in obtaining the Certificate of Creditable Coverage, if needed.]

[Benefits for those persons who become members of the Group after the effective date of the Group Policy will be limited to a maximum of $[500–60,000] for Covered Services rendered in connection with a Preexisting Condition during the Preexisting Condition waiting period, if applicable.] 37.32b

[This Preexisting Condition waiting period does not apply to those persons who were members of the Group and applied for coverage at the time that the Group initially purchased this coverage.] 37.31a

[This Preexisting Condition waiting period does not apply to those persons who were members of the Group and applied for coverage at the time that the Group initially purchased health insurance from Blue Cross and Blue Shield. However, this Preexisting Condition waiting period will be waived only if the member had health insurance with the Group immediately prior to the date the Group initially purchased health insurance from Blue Cross and Blue Shield or had 63 days of Creditable Coverage.

You should be aware that the date your group initially purchased health insurance from Blue Cross and Blue Shield may be different than the date your Group purchased the particular coverage described in this Certificate.] 37.31b

[However, benefits for initial enrollees will be limited to a maximum of $[500–60,000] for Covered Services rendered in connection with a Preexisting Condition during the first 365 days of coverage.] 37.32a

[The Preexisting Condition waiting period does not apply to the following benefit section(s) of this Certificate: [Outpatient Prescription Drug Program Benefit Section, Vision Care Program, Hearing Care Program, and Dental Benefit Section].] 37.3

TERMINATION OF COVERAGE

You will no longer be entitled to the benefits described in this Certificate if either of the events stated below should occur.

1. If you no longer meet the previously stated description of an Eligible Person.
2. If the entire coverage of your Group terminates.

Termination of the Group Policy automatically terminates your coverage under this Certificate. It is the responsibility of your Group to notify you of the termination of the Group Policy, but your coverage will automatically terminate as of the effective date of termination of the Group Policy regardless of whether such notice is given.

No benefits are available to you for services or supplies rendered after the date of termination of your coverage under this Certificate[except as][otherwise specifically stated in the "Extension of Benefits in Case of Termination" provision of this Certificate][or as][specified below when your entire Group's coverage terminates]. However, termination of the Group Policy and/or your coverage under this Certificate shall not affect any Claim for Covered Services rendered prior to the effective date of such termination.

[Unless specifically mentioned elsewhere in this Certificate, if one of your dependents becomes ineligible, his or her coverage will end as of the date the event occurs

which makes him or her ineligible (for example, date of marriage, date of divorce, date the limiting age is reached).]

[Upon the death of an Eligible Person, dependents under his or her family coverage will have the option to continue coverage for a period of 90 days subject to any other Certificate provisions relating to termination of such person's coverage, provided such person makes payment for coverage.] 37.2

Other options available for continuation of coverage are explained in the Continuation of Coverage After Termination Sections of this Certificate.

[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.] 37.4

[Extension of Benefits In Case of Discontinuance

[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. It is your responsibility to notify Blue Cross and Blue Shield, and to provide, when requested by Blue Cross and Blue Shield, written documentation of such disability. [This extension of benefits will not apply to the following benefit section(s) of this Certificate: [Outpatient Prescription Drug Program Benefit Section, Vision Care Program, Hearing Care Program, and Dental Benefit Section].] 37.5 37.51

[CONVERSION PRIVILEGE

If your coverage under this Certificate should terminate and you want to continue Blue Cross and Blue Shield coverage with no interruption, you may do so if you have been insured under this coverage for at least 3 months and your Group has not cancelled this coverage and replaced it with other coverage. Here is what to do:

1. Tell Blue Cross and Blue Shield or your Group Administrator that you wish to continue your coverage and you will be provided with the necessary application.
2. Send the application and first premium to Blue Cross and Blue Shield within 31 days of the date you leave your Group or within 15 days after you have been given written notice of the conversion privilege, but in no event later than 60 days after you leave your Group.

Having done so, you will then be covered by Blue Cross and Blue Shield on an individual "direct pay" basis. This coverage will be effective from the date your Group coverage terminates so long as the premiums charged for the direct pay coverage are paid when due.

These direct pay benefits (and the premium charged for them) may not be exactly the same as the benefits under this Certificate. However, by converting your coverage, your health care benefits are not interrupted and you will not have to repeat waiting periods (if any).

[Should any or all of your dependents become ineligible for coverage under this Certificate, they may convert to direct pay coverage by following the instructions stated above.]] 37.2

MEDICAL SERVICES ADVISORY PROGRAM

Blue Cross and Blue Shield has established the Medical Services Advisory Program (MSA) to perform a review of Inpatient Hospitalthe following Covered Services **prior to** such services being rendered.: 1.12 1.13

- Inpatient Hospital services 1.13
- Skilled Nursing Facility services 1.135
- services received in a Coordinated Home Care Program 1.136
- services received in a Partial Hospitalization Treatment Program 1.19
- home infusion therapy services 1.133
- Private Duty Nursing Services 1.134
- certain Outpatient procedures 1.15

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

Failure to contact the MSA or to comply with the determinations of the MSA will result in a reduction in benefits. The MSA's toll-free telephone number is on your Blue Cross and Blue Shield identification card. Please read the provisions below very carefully. 1.16

NOTE: When you choose to receive Covered Services, other than for maternity,from a Participatingan In-Network Provider in Illinois, you will not be responsible for notifying the MSA, and the provisions of this MSA PROGRAM section will not apply to you. When you receive Covered Services for maternity, you are responsible for calling the MSA as described in the Maternity Admission Review provision below. 1.14

The provisions of the MSA PROGRAM section do not apply to the treatment of Mental Illness and Substance Abuse Rehabilitation Treatment. The provisions for the treatment of Mental Illness and Substance Abuse Rehabilitation Treatment are specified in the BLUE CROSS AND BLUE SHIELD MENTAL HEALTH UNIT section of this Certificate. 29.0

PREADMISSION REVIEW

- **Inpatient Hospital Preadmission Review**

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

  Whenever a nonemergency or nonmaternity Inpatient Hospital admission is recommended by your Physician, you must, in order to receive maximum benefits under this Certificate, call the MSA. This call must be made at least onethree business days prior to the Hospital admission. 1.16 1.20a 1.20b

  If the proposed Hospital admission or health care services are not Medically Necessary, it will be referred to a Blue Cross and Blue Shield Physician for

review. If the Blue Cross and Blue Shield Physician concurs that the proposed admission or health care services are not Medically Necessary, some days, services or the entire hospitalization will be denied. The Hospital and your Physician will be advised by telephone of this determination, with a follow-up notification letter sent to you, your Physician and the Hospital. The MSA will issue these notification letters promptly. However, in some instances, these letters will not be received prior to your scheduled date of admission.

- **Emergency Admission Review**

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

  In the event of an emergency admission, you or someone who calls on your behalf must, in order to receive maximum benefits under this Certificate, notify the MSA no later than onetwo business days or as soon as reasonably possible after the admission has occurred. If the call is made any later than the specified time period, you will not be eligible for maximum benefits. 1.16 1.21a 1.21b

- **Maternity Admission Review**

  Maternity admission review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations and exclusions of this Certificate.

  In the event of a maternity admission, you or someone who calls on your behalf must, in order to receive maximum benefits under this Certificate, notify the MSA no later than onetwo business days after the admission has occurred in order to have the Inpatient Hospital admission reviewed. If the call is made any later than the specified time period, you will not be eligible for maximum benefits. 1.16 1.131 1.132 1.13a 1.16

  When you are pregnant, you or someone who calls on your behalf must, in order to receive maximum benefits under this Certificate, notify the MSA before the end of your first trimester of pregnancy. If the call is made any later than the specified time period, you will not be eligible for maximum benefits. 1.16 1.13b 1.16

  Even though you are not required to call the MSA prior to your maternity admission, if you call the MSA as soon as you find out you are pregnant, the MSA will begin to monitor your case. When you contact the MSA, you will be asked to answer a series of questions regarding your pregnancy. The MSA will provide you with educational materials which will be informative for you and which you may want to discuss with your Physician. A letter will be sent to your Physician stating that you contacted the MSA. The MSA will monitor your case and will be available should you have questions about your maternity benefits. 1.18a 1.18b

- **Skilled Nursing Facility Preadmission Review**

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

Whenever an admission to a Skilled Nursing Facility is recommended by your Physician, you must, in order to receive maximum benefits under this Certificate, call the MSA. This call must be made at least onethree business days prior to the scheduling of the admission. When you call the MSA, a case manager may be assigned to you for the duration of your care. 1.16 1.135

- **Coordinated Home Care Program Preadmission Review**

  Coordinated Home Care Program preadmission review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of this Certificate as well as the Preexisting Condition waiting period, if any.

  Whenever an admission to a Coordinated Home Care Program is recommended by your Physician, you must, in order to receive maximum benefits under this Certificate, call the MSA. This call must be made at least onethree business days prior to the scheduling of the admission. When you call the MSA, a case manager may be assigned to you for the duration of your care. 1.16 1.136

- **Home Infusion Therapy Review**

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

  Whenever home infusion therapy is recommended by your Physician, you must, in order to receive maximum benefits under this Certificate, call the MSA. This call must be made at least onethree business days prior to receiving services. When you call the MSA, a case manager may be assigned to you for the duration of your care. 1.16 1.133

- **Partial Hospitalization Treatment Preadmission Review**

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

  Whenever an admission to a Partial Hospitalization Treatment Program is recommended by your Physician, you must, in order to receive maximum benefits under this Certificate, call the MSA. This call must be made at least onethree business days prior to the scheduling of the admission. 1.16 1.19

- **Private Duty Nursing Service Review**

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

  Whenever Private Duty Nursing Service is recommended by your Physician, you must, in order to receive maximum benefits under this Certificate, call the MSA. This call must be made at least onethree business days prior to receiving services. When you call the MSA, a case manager may be assigned to you for the duration of your care. 1.16 1.134

CASE MANAGEMENT

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

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

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

LENGTH OF STAY/SERVICE REVIEW

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

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

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

OUTPATIENT SERVICE REVIEW

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

Whenever specific Outpatient services are recommended by your Physician, you must, in order to receive maximum benefits under this Certificate, call the MSA. 1.16
This call must be made at least onethree business days prior to the scheduling of the planned Outpatient services. The MSA will obtain information regarding the Outpatient service(s) and may talk with your Physician.

Outpatient services that require review are:

- Adenoidectomy
- Arthroscopy
- Blepharoplasty
- Bronchoscopy
- Cardiac Catherization
- Carpal Tunnel Release

- Chemonucleolysis
- Circumcision (not applicable to newborns)
- Colonoscopy
- Cystoscopy
- D & C
- Foot Surgery
- Gastroscopy
- Hemorrhoidectomy
- Knee Surgery
- Laparoscopy
- Myringotomy
- Nasal Surgery
- Tonsillectomy
- Vein Surgery 1.15a

Outpatient services that require review are:

- Bunionectomy
- Carpal Tunnel Release
- Knee Arthroscopy/Arthroscopic Knee Surgery
- Laparoscopic Cholecystectomy
- MRI Brain or Spine
- Myelography
- Myringotomy (with or without tubes)
- Pelvic Laparoscopy (without tubal ligation)
- Tonsillectomy (with or without Adenoidectomy) 1.15b

If an Inpatient emergency admission occurs after an Outpatient service, in order to receive maximum benefits under this Certificate, an additional call must be made to the MSA for an **"Emergency Admission Review."** 1.16 1.15

MEDICALLY NECESSARY DETERMINATION

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

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

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

Remember that your Blue Cross and Blue Shield Certificate does not cover the cost of hospitalization or any health care services and supplies that are not Medically Necessary. The fact that your Physician or another health care Provider may prescribe, order, recommend or approve a Hospital stay or other health care service or supply does not of itself make such hospitalization, service or supply Medically Necessary. Even if your Physician prescribes, orders, recommends, approves, or views hospitalization or other health care services or supplies as Medically Necessary, Blue Cross and Blue Shield will not pay for the hospitalization, services or supplies if the MSA and the Blue Cross and Blue Shield Physician decide they were not Medically Necessary.

MSA PROCEDURE

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

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

When you contact the MSA, the MSA:

1. will review the medical information provided and may follow up with the Provider;
2. may refer you to a Participatingan In-Network Provider for service; 1.11
3. may determine that the services to be rendered are not Medically Necessary.

APPEAL PROCEDURE

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

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

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

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

Once you have requested this review, you may submit additional information and comments on your Claim to Blue Cross and Blue Shield as long as you do so within 30 days of the date you asked for a review. Also, during this 30 day period, you may

review any relevant documents held by Blue Cross and Blue Shield, if you request an appointment in writing.

Within 30 days of receiving your request for review, Blue Cross and Blue Shield will send you its decision on the Claim. In unusual situations, an additional 15 days may be needed for the review and you will be notified of this during the first 30 day period.

FAILURE TO NOTIFY

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

Should you fail to notify the MSA as required in the Preadmission Review provision of this section, you will then be responsible for the first $ % of the Hospital or facility charges for an eligible stay or $ % of the charges for eligible Covered Services for Private Duty Nursing or home infusion therapy in addition to any deductibles, Copayments and/or Coinsurance applicable to this Certificate. This amount shall not be eligible for later consideration as an unreimbursed expense under any Benefit Section of this Certificate nor can it be applied to your out-of-pocket expense limit, if applicable to this Certificate. 1.161 1.16 1.16a 1.16b

Should you fail to notify the MSA as required prior to receiving Outpatient services, you will then be responsible for $ % of the charges, for eligible Covered Services in addition to any deductibles, Copayments and/or Coinsurance applicable to this Certificate. This amount shall not be eligible for later consideration as an unreimbursed expense under any Benefit Section of this Certificate nor can it be applied to your out-of-pocket expense limit, if applicable to this Certificate. 1.17 1.17a 1.17b

MEDICARE ELIGIBLE MEMBERS

The provisions of this Medical Services Advisory Program do not apply to you if you are Medicare Eligible and have secondary coverage provided under this Certificate.

BLUE CROSS AND BLUE SHIELD
MENTAL HEALTH UNIT

The Blue Cross and Blue Shield Mental Health Unit has been established to perform preadmission review and length of stay review for your Inpatient Hospital services for the treatment of Mental Illness and Substance Abuse. The Mental Health Unit is staffed primarily by Physicians, Psychologists, Clinical Social Workers and registered nurses. 29.1a

The Blue Cross and Blue Shield Mental Health Unit has been established to perform preadmission review and length of stay review for your Inpatient and Outpatient services for the treatment of Mental Illness and Substance Abuse. The Mental Health Unit is staffed primarily by Physicians, Psychologists, Clinical Social Workers and registered nurses. 29.2a

Failure to contact the Mental Health Unit or to comply with the determinations of the Mental Health Unit will result in a reduction of benefits. The Mental Health Unit may be reached twenty-four (24) hours a day, 7 days a week at the toll-free telephone number 1-800-851-7498. Please read the provisions below very carefully.

> **NOTE: When you choose to receive Covered Services from a Participating an In-Network Provider, you will not be responsible for notifying the Mental Health Unit, and the provisions of this MENTAL HEALTH UNIT section will not apply to you.** 29.08

PREADMISSION REVIEW

- **Inpatient Hospital Preadmission Review**

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

  Whenever a nonemergency Inpatient Hospital admission for the treatment of Mental Illness or Substance Abuse is recommended by your Physician, you must, in order to receive maximum benefits under this Certificate, call the Mental Health Unit. This call must be made at least one day three business days prior to the Hospital admission. 29.5a 29.5b

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

- **Emergency Mental Illness Admission Review**

  Emergency Mental Illness Admission review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms,

conditions, limitations, and exclusions of this Certificate as well as the Preexisting Condition waiting period, if any.

In the event of an Emergency Mental Illness Admission, you or someone who calls on your behalf must, in order to receive maximum benefits under this Certificate, notify the Mental Health Unit no later than 24 hours 48 hours one business day or as soon as reasonably possible after the admission has occurred. If the call is made any later than the specified time period, you will not be eligible for maximum benefits. 29.6a 29.6b 29.6c

- **Partial Hospitalization Treatment Program Review**

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

  Whenever an admission to a Partial Hospitalization Treatment Program is recommended by your Physician, you must, in order to receive maximum benefits under this Certificate, call the Mental Health Unit. This call must be made at least one day three business days prior to the admission.

- **Length of Stay Review**

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

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

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

OUTPATIENT SERVICE REVIEW

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

Whenever Outpatient services for the treatment of Mental Illness or Substance Abuse are recommended by your Physician, Psychologist or Clinical Social Worker you must, in order to receive maximum benefits under this Certificate, call the Mental Health Unit. This call must be made at least one day prior to the scheduling of the planned Outpatient service. The Mental Health Unit will obtain information regarding the Outpatient service(s) and may discuss proposed treatment with your Physician, Psychologist or Clinical Social Worker. 29.2

MEDICALLY NECESSARY DETERMINATION

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

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

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

Remember that your Blue Cross and Blue Shield Certificate does not cover the cost of hospitalization or any health care services and supplies that are not Medically Necessary. The fact that your Physician or another health care Provider may prescribe, order, recommend or approve a Hospital stay or other health care service or supply does not of itself make such hospitalization, service or supply Medically Necessary. Even if your Physician prescribes, orders, recommends, approves, or views hospitalization or other health care services or supplies as Medically Necessary, Blue Cross and Blue Shield will not pay for the hospitalization, services or supplies if the Mental Health Unit Physician decides they were not Medically Necessary.

MENTAL HEALTH UNIT PROCEDURE

When you contact the Mental Health Unit, you should be prepared to provide the following information:

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

When you contact the Mental Health Unit, the Mental Health Unit:

1. will review the medical information provided and follow-up with the Provider;
2. will refer you to a specific Provider for service; 0.361
3. may determine that the services to be rendered are not Medically Necessary.

APPEAL PROCEDURE

Expedited Appeal

If you or your Physician disagree with the determinations of the Mental Health Unit prior to or while receiving services, you or the Provider may appeal that determination by contacting the Mental Health Unit and requesting an expedited appeal. The Mental Health Unit Physician will review your case and determine whether the service was Medically Necessary. You and/or your Provider will be notified of the Mental Health Unit Physician's determination within twenty-four (24) hours or no later than the last authorized day. If you or your Provider still disagree with the Mental Health Unit Physician, you may request an appeal in writing as outlined below.

Written Appeal

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

Blue Cross and Blue Shield of Illinois
Appeals Coordinator
Blue Cross and Blue Shield Mental Health Unit
P. O. Box 805107
Chicago, Illinois 60680-4112

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

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

Within 30 days of receiving your request for review, Blue Cross and Blue Shield will send you its decision on the Claim. In unusual situations, an additional 15 days may be needed for the review and you will be notified of this during the first 30 day period.

FAILURE TO NOTIFY

The final decision regarding your course of treatment is solely your responsibility and the Mental Health Unit will not interfere with your relationship with any Provider. However, the Mental Health Unit has been established for the specific purpose of assisting you in maximizing your benefits provided under this Certificate.

Should you fail to notify the Mental Health Unit as required in the Preadmission Review provision of this section, you will then be responsible for the first $%$[100–1,000] or [5–50]%, whichever is less, of the Hospital charges for an eligible Hospital stay in addition to any deductibles, Copayments and/or Coinsurance applicable to this Certificate. This amount shall not be eligible for later consideration as an unreimbursed expense under any Benefit Section of this

Certificate nor can it be applied to your out-of-pocket expense limit, if applicable to this Certificate. 29.03 29.03a 29.03b **New 29.03c**

Should you fail to notify the Mental Health Unit, as required, prior to receiving Outpatient services, you will then be responsible for the first $ %$[100–1,000] or [5–50]%, whichever is less, of the charges for eligible Covered Services in addition to any deductibles, Copayments and/or Coinsurance applicable to this Certificate. This amount shall not be eligible for later consideration as an unreimbursed expense under any Benefit Section of this Certificate nor can it be applied to your out-of-pocket expense limit, if applicable to this Certificate. 29.04 29.04a 29.04b **New 29.04c**

INDIVIDUAL BENEFITS MANAGEMENT PROGRAM ("IBMP")

In addition to the benefits described in this Certificate, if your condition would otherwise require continued care in a Hospital or other health care facility, provision of alternative benefits for services rendered by a Plana Participatingan In-Network Provider in accordance with an alternative treatment plan may be available to you.

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

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

MEDICARE ELIGIBLE MEMBERS

The provisions of the BLUE CROSS AND BLUE SHIELD MENTAL HEALTH UNIT section do not apply to you if you are Medicare Eligible and have secondary coverage provided under this Certificate.

BLUE CROSS AND BLUE SHIELD
MENTAL HEALTH UNIT

[The Blue Cross and Blue Shield Mental Health Unit has been established to assist in the administration of Mental Illness and Substance Abuse Rehabilitation Treatment benefits, including Preauthorization review and length of stay/service review for your Inpatient Hospital admissions for the treatment of Mental Illness and Substance Abuse disorders. The Mental Health Unit has staff which includes Physicians, Psychologists, Clinical Social Workers and registered nurses.] **Revised 1/11** 29.1

[The Blue Cross and Blue Shield Mental Health Unit has been established to assist in the administration of Mental Illness and Substance Abuse Rehabilitation Treatment benefits, including Preauthorization review, Emergency Mental Illness or Substance Abuse Admission Review and length of stay/service review for your Inpatient Hospital admissions and/or Outpatient services for the treatment of Mental Illness and Substance Abuse disorders. The Mental Health Unit has staff which includes Physicians, Psychologists, Clinical Social Workers and registered nurses.] **Revised 1/11** 29.2

[[Failure to contact the Mental Health Unit or to comply with the determinations of the Mental Health Unit[will][may] result in a reduction of benefits.] The Mental Health Unit may be reached twenty-four (24) hours a day, 7 days a week at the toll-free telephone number [on your Blue Cross and Blue Shield identification card][1-800-851-7498]. Please read the provisions below very carefully.] **Revised 1/11**

[**You are responsible for satisfying Preauthorization requirements. This means that you must ensure that you, your family member, your Behavioral Health Practitioner or Provider of services must comply with the guidelines below. Failure to Preauthorize services will require additional steps and/or benefit reductions as described in the provision entitled FAILURE TO PREAUTHORIZE OR NOTIFY.**] **New 1/11**

[**NOTE: When you choose to receive Covered Services from[a Participating][an In-Network] Provider, you will not be responsible for notifying the Mental Health Unit, and the provisions of this MENTAL HEALTH UNIT section will not apply to you.**] 29.08

PREAUTHORIZATION REVIEW **Revised 1/11**

- **Inpatient Hospital Preauthorization Review** **Revised 1/11**

  Preauthorization review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of this Certificate as well as the Preexisting Condition waiting period, if any. **Revised 1/11**

  In order to receive maximum benefits under this Certificate, you must Preauthorize your nonemergency Inpatient Hospital admission for the treatment of Mental Illness or Substance Abuse by calling the Mental Health Unit.[[Participating and Non-Participating][In-Network and Out-of-Network]Providers may Preauthorize services for you, when required, but it is your responsibility to ensure Preauthorization requirements are satisfied.] This call must be made[at least][one three][business][days][[24–96] hours] prior to the Inpatient Hospital admission. **Revised 1/11**

- **Emergency Mental Illness or Substance Abuse Admission Review** **Revised 1/11**

  Emergency Mental Illness or Substance Abuse Admission review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of this Certificate as well as the Preexisting Condition waiting period, if any. **Revised 1/11**

  In order to receive maximum benefits under this Certificate, you or someone on your behalf must notify the Mental Health Unit no later than [one][two] business day[s] or as soon as reasonably possible after the admission for the treatment of Mental Illness or Substance Abuse has occurred. If the call is made any later than the specified time period, you will not be eligible for maximum benefits.[[Participating and Non-Participating][In-Network and Out-of-Network]Providers may Preauthorize services for you, when required, but it is your responsibility to ensure Preauthorization requirements are satisfied.] **Revised 1/11**

- [**Partial Hospitalization Treatment Program Preauthorization Review**] **New 1/11**

  [**Partial Hospitalization Treatment Program Preauthorization review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of this Certificate as well as the Preexisting Condition waiting period, if any.**] **New 1/11**

  [In order to receive maximum benefits under this Certificate, you must Preauthorize your treatment of Mental Illness or Substance Abuse Rehabilitation Treatment by calling the Mental Health Unit.[[Participating and Non-Participating][In-Network and Out-of-Network]Providers may Preauthorize services for you, when required, but it is your responsibility to ensure Preauthorization requirements are satisfied.] This call must be made[at least][one threeone-five][business][day(s)][[24–96] hours]] prior to the scheduling of the Partial Hospitalization Treatment Program. The Mental Health Unit will obtain information regarding the service(s) and may discuss proposed treatment with your Behavioral Health Practitioner.] **New 1/11**

  [If an Inpatient Emergency Mental Illness or Substance Abuse Admission occurs after Outpatient service(s), in order to receive maximum benefits under this Certificate, an additional call must be made to the Mental Health Unit for an Emergency Mental Illness or Substance Abuse Admission Review.] **New 1/11**

- **Length of Stay/Service Review** **Revised 1/11**

  Length of stay/service review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of this Certificate as well as the Preexisting Condition waiting period, if any. **Revised 1/11**

  Upon completion of the Preauthorization or Emergency Mental Illness or Substance Abuse Review, the Mental Health Unit will send you a letter confirming that you or your representative called the Mental Health Unit. A letter assigning a length of service or length of stay will be sent to your Behavioral Health Practitioner and/or the Hospital. **Revised 1/11**

  An extension of the length of stay/service will be based solely on whether continued Inpatient care or other health care service is Medically Necessary as

determined by the Mental Health Unit. In the event that the extension is determined not to be Medically Necessary, the length of stay/service will not be extended, and the case will be referred to a Mental Health Unit Physician for review. **Revised 1/11**

[OUTPATIENT SERVICE PREAUTHORIZATION REVIEW] **Revised 1/11** 29.2

- [**Outpatient Service Preauthorization Review**] **New 1/11** 29.2

  [**Outpatient service Preauthorization review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of this Certificate as well as the Pre-existing Condition waiting period, if any.**] **Revised 1/11** 29.2

  [In order to receive maximum benefits under this Certificate for Outpatient services for the treatment of Mental Illness or Substance Abuse, you must Preauthorize the following Outpatient service(s) by calling the Mental Health Unit: **Revised 1/11** 29.2

  - Psychological testing
  - Neuropsychological testing
  - Electroconvulsive therapy
  - Intensive Outpatient Programs

  [[Participating and Non-Participating][In-Network and Out-of-Network]Providers may Preauthorize services for you, when required, but it is your responsibility to ensure Preauthorization requirements are satisfied.] This call must be made[at least][one–five one two three][business][day(s)][[4824–96] hours] prior to the scheduling of the planned Outpatient service. The Mental Health Unit will obtain information regarding the Outpatient service(s) and may discuss proposed treatment with your Behavioral Health Practitioner.]

- [**Partial Hospitalization Treatment Program Preauthorization Review**] **New 1/11**

  [**Partial Hospitalization Treatment Program Preauthorization review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of this Certificate as well as the Preexisting Condition waiting period, if any.**] **New 1/11**

  [In order to receive maximum benefits under this Certificate, you must Preauthorize your Outpatient service(s) for the treatment of Mental Illness or Substance Abuse Rehabilitation Treatment by calling the Mental Health Unit. This call must be made[at least][one-five][business][day (s)][[24-96] hours] prior to the scheduling of the planned Outpatient service(s).[[Participating and Non-Participating][In-Network and Out-of-Network] Providers may Preauthorize services for you, when required, but it is your responsibility to ensure Preauthorization requirements are satisfied.] The Mental Health Unit will obtain information regarding the Outpatient service(s) and may discuss proposed treatment with your Behavioral Health Practitioner.]

  [If an Inpatient Emergency Mental Illness or Substance Abuse Admission occurs after an Outpatient service, in order to receive maximum benefits under

this Certificate, an additional call must be made to the Mental Health Unit for an Emergency Mental Illness or Substance Abuse Admission Review.] **New 1/11** 29.2

MEDICALLY NECESSARY DETERMINATION

The decision that Inpatient Hospital admission[, Outpatient service,] or other health care services or supplies are not Medically Necessary, as such term is defined in this Certificate, will be determined by the Mental Health Unit. If the Mental Health Unit Physician concurs that the Inpatient Hospital admission, Outpatient service, or other health care service or supply does not meet the criteria for Medically Necessary care, some days, services or the entire hospitalization will be denied. Your Behavioral Health Practitioner and in the case of an Inpatient Hospital admissions, the Hospital will be advised by telephone of this determination, with a follow-up notification letter sent to you, your Behavioral Health Practitioner and the Hospital, and will specify the dates, services or supplies that are not considered Medically Necessary. The Mental Health Unit will issue these notification letters promptly. However, in some instances, these letters will not be received prior to your scheduled date of admission or service. For further details regarding Medically Necessary care and other exclusions from coverage under this Certificate, see the provision entitled, "EXCLUSIONS—WHAT IS NOT COVERED." **Revised 1/11**

The Mental Health Unit does not determine your course of treatment or whether you receive particular health care services. The decision regarding the course of treatment and receipt of particular health care services is a matter entirely between you and your Behavioral Health Practitioner. The Mental Health Unit's determination of Medically Necessary care is limited to merely whether a proposed admission, continued hospitalization[, Outpatient service,] or other health care service or supply is Medically Necessary under this Certificate. **Revised 1/11**

In the event that the Mental Health Unit determines that all or any portion of an Inpatient Hospital admission[, Outpatient service,] or other health care service or supply is not Medically Necessary, Blue Cross and Blue Shield will not be responsible for any related Hospital or other health care service or supply charge incurred. **Revised 1/11**

Remember that your Blue Cross and Blue Shield Certificate does not cover the cost of hospitalization or any health care services and supplies that are not Medically Necessary. The fact that your Behavioral Health Practitioner or another health care Provider may prescribe, order, recommend or approve an Inpatient Hospital admission[, Outpatient service,] or other health care service or supply does not of itself make such hospitalization, service or supply Medically Necessary. Even if your Behavioral Health Practitioner prescribes, orders, recommends, approves, or views hospitalization or other health care services or supplies as Medically Necessary, Blue Cross and Blue Shield will not pay for the hospitalization, services or supplies if the Mental Health Unit Physician determines they were not Medically Necessary. **Revised 1/11**

MENTAL HEALTH UNIT PROCEDURE

When you contact the Mental Health Unit to Preauthorize your Inpatient Hospital admission[, Outpatient service,] and/or other service/supply, provide notification of your Emergency Mental Illness or Substance Abuse Admission, or request a length of stay/service review you should be prepared to provide the following information: **Revised 1/11**

1. the name of the attending and/or admitting Behavioral Health Practitioner; **Revised 1/11**
2. the name of the Hospital or facility where the admission and/or service has been scheduled, when applicable; **Revised 1/11**
3. the scheduled admission and/or service date; and
4. a preliminary diagnosis or reason for the admission and/or service.

When you contact the Mental Health Unit to Preauthorize your Inpatient Hospital admission[, Outpatient service,] and/or other service/supply, provide notification of your Emergency Mental Illness or Substance Abuse Admission, or request a length of stay/service review, the Mental Health Unit: **Revised 1/11**

1. will review the medical information provided and follow-up with the Behavioral Health Practitioner; **Revised 1/11**
2. upon request, will advise you of[Participating][In-Network] Providers in the area who may be able to provide the admission and/or services that are the subject of the Preauthorization Review; **Revised 1/11** 0.361
3. may determine that the admission and/or services to be rendered are not Medically Necessary. **Revised 1/11**

APPEAL PROCEDURE

Expedited Appeal

If you or your Behavioral Health Practitioner disagree with the determinations of the Mental Health Unit prior to or while receiving services, you or the Behavioral Health Practitioner may appeal that determination by contacting the Mental Health Unit and requesting an expedited appeal. The Mental Health Unit Physician will review your case and determine whether the service was Medically Necessary. You and/or your Behavioral Health Practitioner will be notified of the Mental Health Unit Physician's determination within twenty-four (24) hours or no later than the last authorized day. If you or your Behavioral Health Practitioner still disagree with the Mental Health Unit Physician, you may request an appeal in writing as outlined below. **Revised 1/11**

Written Appeal

In some instances, the resolution of the appeal process will not be completed until your admission or service has occurred and/or your assigned length of stay/service has elapsed. If you disagree with a decision after Claim processing has taken place or upon receipt of the notification letter from the Mental Health Unit, you may appeal that decision by having your Behavioral Health Practitioner call the contact person indicated in the notification letter or by submitting a written request to: **Revised 1/11**

[Blue Cross and Blue Shield of Illinois]
[Appeals Coordinator]
[Blue Cross and Blue Shield BH Unit]
[P. O. Box 660240]
[Dallas, TX 75266-0240] **Revised 1/11**
[Fax Number: 1-877-361-7656] **Revised 1/11**

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

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

Within 30 days of receiving your request for review, Blue Cross and Blue Shield will send you its decision on the Claim. In unusual situations, an additional 15 days may be needed for the review and you will be notified of this during the first 30 day period.

[FAILURE TO PREAUTHORIZE OR NOTIFY] **Revised 1/11**

[The final decision regarding your course of treatment is solely your responsibility and the Mental Health Unit will not interfere with your relationship with any Behavioral Health Practitioner. However, the Mental Health Unit has been established for the specific purpose of assisting you in maximizing your benefits provided under this Certificate.] **Revised 1/11**

[Should you fail to Preauthorize or notify the Mental Health Unit as required in the Preauthorization Review provision of this section, you will then be responsible for the first $[100–1,000] or [5–50]%, whichever is less, of the Hospital charges for an eligible Hospital stay in addition to any deductibles, Copayments and/or Coinsurance applicable to this Certificate. This amount shall not be eligible for later consideration as an unreimbursed expense under any Benefit Section of this Certificate nor can it be applied to your out-of-pocket expense limit, if applicable to this Certificate.] **Revised 1/11** 29.03

[INDIVIDUAL BENEFITS MANAGEMENT PROGRAM ("IBMP")] **Revised 1/11**

[In addition to the benefits described in this Certificate, if your condition would otherwise require continued care in a Hospital or other health care facility, provision of alternative benefits for services rendered by a Plana Participatingan In-Network Provider in accordance with an alternative treatment plan may be available to you.] **Revised 1/11**

[Alternative benefits will be provided only so long as Blue Cross and Blue Shield determines that the alternative services are Medically Necessary and cost effective. The total maximum payment for alternative services shall not exceed the total benefits for which you would otherwise be entitled under this Certificate.] **Revised 1/11**

[Provision of alternative benefits in one instance shall not result in an obligation to provide the same or similar benefits in any other instance. In addition, the provision of alternative benefits shall not be construed as a waiver of any of the terms, conditions, limitations or exclusions of this Certificate.] **Revised 1/11**

MEDICARE ELIGIBLE MEMBERS

The provisions of the BLUE CROSS AND BLUE SHIELD MENTAL HEALTH UNIT section do not apply to you if you are Medicare Eligible and have secondary coverage provided under this Certificate.

HOSPITAL BENEFIT SECTION

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

The benefits of this section are subject to all of the terms and conditions of this Certificate. Your benefits are also subject to the Preexisting Conditions waiting period. Please refer to the DEFINITIONS, ELIGIBILITY and EXCLUSIONS sections of this Certificate for additional information regarding any limitations and/or special conditions pertaining to your benefits. 0.563

In addition, the benefits described in this section will be provided only when you receive services on or after your Coverage Date and they are rendered upon the direction or under the direct care of your Physician. Such services must be Medically Necessary and regularly included in the Provider's charges.

The level of benefits paid for Hospital Covered Services is generally greater when received in a Plan Hospital or other Plan facility. 1.01

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

INPATIENT CARE

The following are Covered Services when you receive them as an Inpatient in a Hospital. 1.1a

When you receive Inpatient services in your Employer Hospital, benefits will be provided at 100% of the Hospital's Eligible Charge. For Inpatient services you receive at a Hospital other than your Employer Hospital and for all other Hospital Covered Services, the following provisions will apply: 1.1b

Inpatient Covered Services

1. Bed, board and general nursing care when you are in:
   - — a semi-private room
   - — a private room
   - — an intensive care unit
2. Ancillary services (such as operating rooms, drugs, surgical dressings and lab work)

[Number of Hospital days

[For each different accident or illness, you are entitled to benefits for [5–365] days of Inpatient Hospital care (your "Hospital days"). If you should use all of your Hospital days for one illness or accident, they will be reinstated to the full amount each time you are out of the Hospital or other health care facility for 90 days in a row.] 1.3a **Revised**

[You are entitled to benefits for [5–365] days (your "Hospital days") of Inpatient Hospital care. If you should use all of your Hospital days, they will be reinstated to the full

amount each time you are out of the Hospital or other health care facility for 90 days in a row.]] 1.3b

Number of Hospital days

For each different accident or illness (other than Serious Mental Illness), you are entitled to benefits for days of Inpatient Hospital care (your "Hospital days"). If you should use all of your Hospital days for one illness or accident, they will be reinstated to the full amount each time you are out of the Hospital or other health care facility for 90 days in a row. 1.2a

[You are entitled to benefits for [5–365] days (your "Hospital days") of Inpatient Hospital care other than for Serious Mental Illness. If you should use all of your Hospital days, they will be reinstated to the full amount each time you are out of the Hospital or other health care facility for 90 days in a row.] 1.2b

[You are entitled to benefits for [45–365] days each benefit period (your "Hospital days") of Inpatient Hospital care for Serious Mental Illness.] 1.2c

Benefit Payment for Inpatient Covered Services

[Each time you are admitted to a Hospital, you must satisfy a $ deductible. After the deductible, benefits will be provided as follows:] 1.31

[[50–100]% of the Eligible Charge for Inpatient Covered Services will be paid when you receive these services from a Plan Hospital. If you are in a private room, payment for that room will be [50–100]% of the Hospital's rate for its most common type of room with two or more beds.] 1.32a

[100% of the Eligible Charge for Inpatient Covered Services will be paid when you receive these services from a Plan Hospital. If you are in a private room, payment for that room will be 100% of the Hospital's rate for its most common type of room with two or more beds plus an additional $[5–100] per day.] 1.32b

[$[30–300] per day (not to exceed the Eligible Charge) will be paid for bed, board and general nursing care when you are in a semi-private room or a private room of a Plan Hospital and $[30–600] per day (not to exceed the Eligible Charge) when you are in an intensive care unit. Benefits for ancillary services will be provided at 100% of the Eligible Charge. 1.32c

[100% of the Eligible Charge for Inpatient Covered Services will be paid when you receive these services from a Plan Hospital, up to $[1,000–30,000] for each Hospital admission. Any remaining charges will be paid at 80% of the Eligible Charge. If you are in a private room, payment for that room will be limited by the Hospital's rate for its most common type of room with two or more beds.] 1.32d

[When you receive services from a Non-Plan Hospital, benefits will be provided at 50% of the Eligible Charge.] 1.33a

[When you receive services from a Non-Plan Hospital, benefits will be provided at 80% of the amount you would have received had you received them from a Plan Hospital.] 1.33b

[However, benefits for an Inpatient Hospital admission to a Non-Plan Hospital resulting from Emergency Accident Care or Emergency Medical Care will be provided at

the same payment level which you would have received had you been in a Plan Hospital for that portion of your Inpatient Hospital stay during which your condition is reasonably determined by Blue Cross and Blue Shield to be serious and therefore not permitting your safe transfer to a Plan Hospital or other Plan Provider. 1.33a

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

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

[Your benefits for the treatment of Mental Illness for those illnesses not classified as Serious Mental Illness and Substance Abuse Rehabilitation Treatment will be provided at the payment level specified in the TREATMENT OF MENTAL ILLNESS AND SUBSTANCE ABUSE REHABILITATION TREATMENT BENEFIT SECTION of this Certificate. However, benefits for the Inpatient treatment of Substance Abuse (i.e. detoxification and/or treatment of medical complications of Substance Abuse will be provided as specified in the Benefit Payment for Inpatient Hospital Covered Services provision of this Benefit Section).] 1.64b

OUTPATIENT COVERED SERVICES

The following are Covered Services when received from a Hospital as an Outpatient.

Outpatient Covered Services

1. Emergency Accident Care—Treatment must occur within 72 hours of the accident or as soon as reasonably possible.
2. Emergency Medical Care
3. Surgery and related Diagnostic Service received on the same day as the Surgery.

   In addition to Surgery in a Hospital, benefits will be provided for Outpatient Surgery performed in an Ambulatory Surgical Facility.
4. Radiation Therapy Treatments
5. Chemotherapy—benefits will be provided for Chemotherapy except oral Chemotherapy and subcutaneous and intramuscular injections.
6. Electroconvulsive Therapy—For each treatment received, one day is deducted from your Hospital days.
7. Renal Dialysis Treatments—These treatments are eligible for benefits if you receive them in a Hospital, a Dialysis Facility or in your home under the supervision of a Hospital or Dialysis Facility. For each Renal Dialysis Treatment you receive, one day is deducted from your Hospital days.
8. Mammograms

9. Pap Smear Test—Benefits will be provided for an annual routine cervical smear or Pap smear test for females. Benefits for routine cervical smears or Pap smears will be provided at the same payment level as Outpatient Diagnostic Service.
10. Prostate Test and Digital Rectal Examination—Benefits will be provided for an annual routine prostate–specific antigen test and digital rectal examination for males.
11. Ovarian Cancer Screening—Benefits will be provided for annual ovarian cancer screening for females using CA-125 serum tumor marker testing, transvaginal ultrasound, and pelvic examination.
12. Colorectal Cancer Screening—Benefits will be provided for colorectal cancer screening as prescribed by a Physician, in accordance with the published American Cancer Society guidelines on colorectal cancer screening or other existing colorectal cancer screening guidelines issued by nationally recognized professional medical societies or federal government agencies, including the National Cancer Institute, the Centers for Disease Control and Prevention, and the American College of Gastroenterology.
13. Bone Mass Measurement and Osteoporosis—Benefits will be provided for bone mass measurement and the diagnosis and treatment of osteoporosis.

Benefit Payment for Outpatient Covered Services

[[50–100]% of the Eligible Charge will be paid for Outpatient Covered Services received from a Plan Hospital, Plan Ambulatory Surgical Facility or Plan Dialysis Facility. When you receive Covered Services from a Non-Plan Hospital or other Non-Plan Provider, benefit payment will be 50% of the Eligible Charge.

However, Covered Services received for Emergency Accident Care and Emergency Medical Care from a Non-Plan Hospital will be paid at the same payment level which would have been paid had such services been received from a Plan Hospital or other Plan Provider.] 1.4a

[[50–100] % of the Eligible Charge will be paid for Outpatient Covered Services received from a Plan Hospital, Plan Ambulatory Surgical Facility or Plan Dialysis Facility. When you receive Covered Services from a Non-Plan Hospital or other Non-Plan Provider, benefit payment will be 80% of the amount you would have received had you been in a Plan Hospital or other Plan Provider.] 1.4b

[Also, Covered Services received for Emergency Accident Care and Emergency Medical Care resulting from criminal sexual assault or abuse will be paid at 100% of the Eligible Charge.] 1.41a

[Also, Emergency Medical Care Covered Services for the examination and testing of a victim of criminal sexual assault or abuse to determine whether sexual contact occurred, and to establish the presence or absence of sexually transmitted disease or infection, will be paid at 100% of the Eligible Charge.] 1.41b

SKILLED NURSING FACILITY CARE

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

1. Bed, board and general nursing care

2. Ancillary services (such as drugs and surgical dressings or supplies)

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 Days

One day is deducted from your remaining Hospital days for every two days of care in a Skilled Nursing Facility.

Benefit Payment for Skilled Nursing Facility Care

[[50–100]% of the Eligible Charge will be paid for Covered Services received from a Plan Skilled Nursing Facility. When you receive Covered Services in a Non-Plan Skilled Nursing Facility, benefits will be provided at 50% of the Eligible Charge. Benefits will not be provided for Covered Services received in an Uncertified Skilled Nursing Facility.] 1.51a

[[50–100]% of the Eligible Charge will be paid for Covered Services received from a Plan Skilled Nursing Facility. When you receive Covered Services in a Non-Plan Skilled Nursing Facility, benefits will be provided at 80% of the amount that would have been paid had you received services in a Plan Skilled Nursing Facility. Benefits will not be provided for Covered Services received in an Uncertified Skilled Nursing Facility.] 1.51b

[$[30–300] per day (not to exceed the Eligible Charge) will be paid for Covered Services when received in a Plan Skilled Nursing Facility. When you receive Covered Services in a Non-Plan Skilled Nursing Facility, benefits will be provided at 50% of the Eligible Charge. Benefits will not be provided for Covered Services received in an Uncertified Skilled Nursing Facility.] 1.51c

[$[30–300] per day (not to exceed the Eligible Charge) will be paid for Covered Services when received in a Plan Skilled Nursing Facility. When you receive Covered Services in a Non-Plan Skilled Nursing Facility, benefits will be provided at 80% of the amount that would have been paid had you received services in a Plan Skilled Nursing Facility. Benefits will not be provided for Covered Services received in an Uncertified Skilled Nursing Facility.] 1.51d

[When you receive Covered Services in a Skilled Nursing Facility, benefits will be provided the same as that previously described for Inpatient Covered Services. Benefits will not be provided for Covered Services received in an Uncertified Skilled Nursing Facility. When you are Inpatient in a Hospital prior to your admission to a Skilled Nursing Facility, your admission to a Skilled Nursing Facility is considered a continuation of your Inpatient stay and benefit payment will be the same as that previously described for Inpatient Covered Services.] 1.51e

PREADMISSION TESTING

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

Benefit Payment for Preadmission Testing

[[50–100]% of the Eligible Charge will be paid for these tests when received from a Plan Hospital.] 1.61a

[These tests are considered part of your Inpatient surgical stay and payment will be the same as that previously described for Inpatient Covered Services.] 1.61b

[PARTIAL HOSPITALIZATION TREATMENT PROGRAM

[You must be admitted to this program within 72 hours of discharge from a covered Inpatient Hospital admission.]Benefits are available for this program only if it is a Blue Cross and Blue Shield approved program. No benefits will be provided for services received in a Partial Hospitalization Treatment Program which has not been approved by Blue Cross and Blue Shield. 1.02

[[50–100]% of the Eligible Charge will be paid for this treatment provided that benefits would have been available to you had you received this treatment as an Inpatient in a Hospital. For each day of care in this program, one day is deducted from your Hospital days.] 1.62a

[Benefit payment will be the same as that previously described for Inpatient Covered Services. For each day of care in this program, one day is deducted from your Hospital days.] 1.62b

[Benefits for Covered Services received in a Partial Hospitalization Treatment Program will be provided at the payment level specified for Inpatient treatment of Mental Illness for those illnesses not classified as Serious Mental Illness and Inpatient Substance Abuse Rehabilitation Treatment in the TREATMENT OF MENTAL ILLNESS AND SUBSTANCE ABUSE REHABILITATION TREATMENT BENEFIT SECTION of this Certificate.]] 1.64b

COORDINATED HOME CARE PROGRAM

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

[100% of the Eligible Charge will be paid for these services when rendered under a Plan Coordinated Home Care Program. When you receive services under a Non-Plan Coordinated Home Care Program, benefits will be provided at 50% of the Eligible Charge.] 1.63a

[100% of the Eligible Charge will be paid for these services when rendered under a Plan Coordinated Home Care Program. When you receive services under a Non-Plan Coordinated Home Care Program, benefits will be provided at 80% of the amount that would have been paid had you received services under a Plan Coordinated Home Care Program.] 1.63b

One day is deducted from your Hospital days for every three visits received under a Coordinated Home Care Program.

SPECIAL CONDITIONS

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

Human Organ Transplants

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

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

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

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

Benefits will be provided for:

— Inpatient and Outpatient Covered Services related to the transplant Surgery.

— the evaluation, preparation and delivery of the donor organ.

— the removal of the organ from the donor.

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

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

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

— If 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 [30–200] miles from the Hospital where the transplant will be performed.][1.72

- You and your companion are each entitled to benefits for lodging and meals up to a combined maximum of $[100–5,000] per day.][1.721a

- You and your companion are each entitled to benefits for lodging up to a combined maximum of $[100–5,000] per day.][1.721b
- Benefits for transportation, lodging and meals are limited to a maximum of $[1,000–30,000] per transplant.][1.722a
- Benefits for transportation, lodging and meals are limited to a lifetime maximum of $[1,000–30,000].] 1.722b

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

- Cardiac rehabilitation services when not provided to the transplant recipient immediately following discharge from a Hospital for transplant Surgery.
- Travel time and related expenses required by a Provider.
- Drugs which do not have approval of the Food and Drug Administration.
- Storage fees.
- Services provided to any individual who is not the recipient or actual donor, unless otherwise specified in this provision.

[**Mental Illness Services**

Your benefits for the diagnosis and/or treatment of a Mental Illness are the same as your benefits for any other condition.] 1.60 **New**

[**Substance Abuse Rehabilitation Treatment**

Your benefits for Substance Abuse Rehabilitation Treatment are the same as your benefits for any other condition. In addition, benefits will be provided if Covered Services are rendered by a Substance Abuse Treatment Facility. Substance Abuse Rehabilitation Treatment Covered Services rendered in a program that does not have a written agreement with Blue Cross and Blue Shield or in a Non-Plan Provider facility will be paid at the Non-Plan Provider facility payment level.] 1.60 **New**

[**Substance Abuse Rehabilitation Treatment** 1.61

Benefits for all of the Covered Services previously described are available for Substance Abuse Rehabilitation Treatment. In addition, benefits will be provided if these Covered Services are rendered by a Substance Abuse Treatment Facility.

[Benefits for Substance Abuse Rehabilitation Treatment in a program that has a written agreement with Blue Cross and Blue Shield will be provided at the same payment level as for Covered Services in a Plan Hospital. Benefits for Substance Abuse Rehabilitation Treatment in a program that does not have a written agreement with Blue Cross and Blue Shield or in a Non-Plan Substance Abuse Treatment Facility will be provided at the same payment level as for Covered Services in a Non-Plan Hospital.] 1.64a

[Your benefits for Substance Abuse Rehabilitation Treatment will be provided at the payment level specified in the TREATMENT OF MENTAL ILLNESS AND SUBSTANCE ABUSE REHABILITATION TREATMENT BENEFIT SECTION of this Certificate. However, benefits for the Inpatient treatment of Substance Abuse (i.e. de-

toxification and/or treatment of medical complications of Substance Abuse will be provided as specified in the Benefit Payment for Inpatient Hospital Covered Services provision of this Benefit Section.] 1.64b

For each Outpatient treatment received, 1/2 day will be deducted from your remaining Hospital days.] 1.61

Maternity Service

Your benefits for Maternity Service are the same as your benefits for any other condition and are available whether you have Individual Coverage or Family Coverage. Benefits will also be provided for Covered Services rendered by a Certified Nurse-Midwife.

Benefits will be paid for Covered Services received in connection with both normal pregnancy and Complications of Pregnancy. As part of your maternity benefits certain services rendered to your newborn infant are also covered, even if you have Individual Coverage. These Covered Services are: a) the routine Inpatient Hospital nursery charges and b) one Inpatient hearing screening. (If the newborn child needs treatment for an illness or injury, benefits will be available for that care only if you have Family Coverage. You may apply for Family Coverage within 31 days of date of the birth. Your Family Coverage will then be effective from the date of the birth.)

Benefits will be provided for any hospital length of stay in connection with childbirth for the mother or newborn child for no less than 48 hours following a normal vaginal delivery, or no less than 96 hours following a cesarean section. Your Provider will not be required to obtain authorization from Blue Cross and Blue Shield for prescribing a length of stay less than 48 hours (or 96 hours).

[Your coverage also includes benefits for elective abortions if legal where performed.] 1.73

[Infertility Treatment

Benefits will be provided the same as your benefits for any other condition 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 makes 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 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 makes such treatment useless; and

— You have not undergone four completed oocyte retrievals, except that if a live birth followed a completed oocyte retrieval, two more completed oocyte retrievals shall be covered.

Benefits will also be provided for medical expenses of an oocyte or sperm donor for procedures used to retrieve oocytes or sperm and the subsequent procedure 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 that are eligible for coverage 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.

Special Limitations

Benefits will not be provided for the following:

a. 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.

b. Selected termination of an embryo; provided, however, termination will be covered where the mother's life would be in danger if all embryos were carried to full term.

c. Expenses incurred for cryo-preservation or storage of sperm, eggs or embryos, except for those procedures which use a cryo-preserved substance.

d. Non-medical costs of an egg or sperm donor.

e. Travel costs for travel within 100 miles of your home or travel costs not Medically Necessary or required by Blue Cross and Blue Shield.

f. Infertility treatments which are deemed Investigational, in writing, by the American Society for Reproductive Medicine or the American College of Obstetricians or Gynecologists.

g. Infertility treatment rendered to your dependents under age 18.

In addition to the above provisions, in-vitro fertilization, gamete intrafallopian tube transfer, zygote intrafallopian tube transfer, low tubal ovum transfer and intracytoplasmic sperm injection procedures must be performed at medical facilities that conform to the American College of Obstetricians and Gynecologists guidelines for in-vitro fertilization clinics or to the American Society for Reproductive Medicine minimal standards for programs of in-vitro fertilization.]

[AMBULANCE TRANSPORTATION

Benefits will not be provided for long distance trips or for use of an ambulance because it is more convenient than other transportation.

Ambulance Transportation Benefit Payment **1.8**

[$[5–500] per trip will be paid for Ambulance Transportation.] 1.81a

[The first $[5–500] per trip will be paid in full for Ambulance Transportation and then 80% of any remaining Eligible Charge.] 1.81b

[[50–100]% of the Eligible Charge per trip will be paid for ambulance transportation.]] 1.81c

PROSTHETIC APPLIANCES

Benefits will be provided for prosthetic devices, special appliances and surgical implants required by you 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.

Benefits will also be provided for adjustments, repair and replacements of covered prosthetic devices, special appliances and surgical implants when required because of wear or change in a patient's condition (excluding dental appliances [other than intra-oral devices used in connection with the treatment of Temporomandibular Joint Dysfunction and Related Disorders, subject to specific limitations applicable to Temporomandibular Joint Dysfunction and Related Disorders,]and replacement of cataract lenses when a prescription change is not required). 1.30

EXTENSION OF BENEFITS IN CASE OF TERMINATION

If you are an Inpatient in a Hospital, Skilled Nursing Facility[or Substance Abuse Treatment Facility or a patient in a Partial Hospitalization Treatment Program] or Coordinated Home Care Program at the time your coverage under this Certificate is terminated, the benefits of this benefit section will be provided until you are discharged from the Hospital or other Provider, or until your Hospital days are exhausted, whichever occurs first.

PHYSICIAN BENEFIT SECTION

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

The benefits of this section are subject to all the terms and conditions of this Certificate.[Your benefits are also subject to the Preexisting Conditions waiting period.] Please refer to the DEFINITIONS, ELIGIBILITY and EXCLUSIONS sections of this Certificate for additional information regarding any limitations and/or special conditions pertaining to your benefits. 0.567

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

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

COVERED SERVICES

Surgery

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

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

The following services are also part of your surgical benefits:

1. Human Organ Transplants—Your benefits for certain human organ transplants are the same as your benefits for any other condition. Benefits will be provided only for cornea, kidney, bone marrow, heart valve, muscular-skeletal, parathyroid, heart, lung, heart/lung, liver, pancreas or pancreas/kidney human organ or tissue transplants. Benefits are available to both the recipient and donor of a covered transplant as follows:
   - — If both the donor and recipient have Blue Cross and Blue Shield coverage each will have their benefits paid by their own Blue Cross and Blue Shield program.
   - — If you are the recipient of the transplant, and the donor for the transplant has no coverage from any other source, the benefits under this Certificate

will be provided for both you and the donor. In this case, payments made for the donor will be charged against your benefits.

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

Benefits will be provided for:

— Inpatient and Outpatient Covered Services related to the transplant Surgery.

— the evaluation, preparation and delivery of the donor organ.

— the removal of the organ from the donor.

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

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

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

— Benefits for transportation are described in the Hospital Benefit Section of this Certificate.] 1.72

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

- Cardiac rehabilitation services when not provided to the transplant recipient immediately following discharge from a Hospital for transplant Surgery.
- Travel time and related expenses required by a Provider.
- Drugs which do not have approval of the Food and Drug Administration.
- Storage fees.
- Services provided to any individual who is not the recipient or actual donor, unless otherwise specified in this provision.

2. Anesthesia Services—if administered at the same time as a covered surgical procedure in a Hospital or Ambulatory Surgical Facility or by a Physician other than the operating surgeon or by a Certified Registered Nurse Anesthetist. However, benefits will be provided for anesthesia services administered by oral and

maxillofacial surgeons when such services are rendered in the surgeon's office or Ambulatory Surgical Facility.

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

3. Assist at Surgery—when performed by a Physician, Dentist or Podiatrist who assists the operating surgeon in performing covered Surgery in a Hospital or Ambulatory Surgical Facility. In addition, benefits will be provided for assist at Surgery when performed by a Registered Surgical Assistant or an Advanced Practice Nurse. Benefits will also be provided for assist at Surgery performed by a Physician Assistant under the direct supervision of a Physician, Dentist or Podiatrist.][2.1
4. Sterilization procedures (even if they are elective).] 2.8

[Additional Surgical Opinion

Your coverage includes benefits for an additional surgical opinion following a recommendation for elective Surgery. Your benefits will be limited to one consultation and related Diagnostic Service by a Physician.[Benefits for an additional surgical opinion consultation and related Diagnostic Service will be provided at 100% of the Usual and Customary Fee.][Your deductible will not apply to this benefit.] If you request, benefits will be provided for an additional consultation when the need for Surgery, in your opinion, is not resolved by the first arranged consultation.] 2.6

Medical Care

Benefits are available for Medical Care visits if you are an Inpatient in a Hospital, Skilled Nursing Facility[or Substance Abuse Treatment Facility or a patient in a Partial Hospitalization Treatment Program] or Coordinated Home Care Program.

[You are entitled to benefits for one Medical Care visit during each of your Hospital days. If you are under the care of more than one Physician and receive more than one visit in a day, a second visit will be covered but only if your condition is severe enough to require treatment by a second Physician. In addition, if you are entitled to benefits for Surgery or Maternity Service, Medical Care visits received during the same admission are not covered (except in unusual situations where specialized Medical Care is Medically Necessary and rendered by a different Physician for a completely different condition).] 2.5a

[You are entitled to Medical Care visits by your Physician during your covered Hospital days. Benefits will be provided for Medical Care visits by a second Physician but only if your condition is severe enough to require treatment by a second Physician. In addition, if you are entitled to benefits for Surgery or Maternity Service, Medical Care visits received during the same admission are not covered (except in unusual situations where specialized Medical Care is Medically Necessary and rendered by a different Physician for a completely different condition.)] 2.5b

Medical Care benefits also include coverage for the following special types of Medical Care:

— Intensive Medical Care—that is, Medical Care rendered in critical cases and which requires special supervision and time by the Physician.[

— Psychiatric Care—that is, Medical Care for the treatment of Mental Illness rendered by (1) a Physician; (2) a Psychologist; (3) a Clinical Social Worker; (4) a Clinical Professional Counselor or (5) a Marriage and Family therapist working within the scope of their license.][2.0a

— Mental Illness Services—that is, Medical Care for the treatment of Mental Illness rendered by (1) a Physician; (2) a Psychologist; (3) a Clinical Social Worker; (4) a Clinical Professional Counselor or (5) a Marriage and Family therapist working within the scope of their license.] **2.0b Revised**

[Your benefits for the treatment of Mental Illness for those illnesses not classified as Serious Mental Illness and Substance Abuse Rehabilitation Treatment will be provided at the payment level specified in the TREATMENT OF MENTAL ILLNESS AND SUBSTANCE ABUSE REHABILITATION TREATMENT BENEFIT SECTION of this Certificate. However, benefits for the Inpatient treatment of Substance Abuse (i.e. detoxification and/or treatment of medical complications of Substance Abuse will be provided as specified in the Benefit Payment for Physician Services provision of this Benefit Section.] 31.0

[**Consultations**

Your coverage includes benefits for consultations when you are an Inpatient in a Hospital or Skilled Nursing Facility. The consultation must be requested by your attending Physician and consist of another Physician's advice in the diagnosis or treatment of a condition which requires special skill or knowledge. Benefits are not available for any consultation provided because of Hospital regulations or by a Physician who renders Surgery or Maternity Service during the same admission, or if performed after you have exhausted the Medical Care visits to which you are entitled under this Certificate.

Your benefits are limited to one consultation during each Inpatient admission.] 2.2

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.

Diagnostic Service

Your coverage includes benefits for Diagnostic Service when you are an Inpatient and when such service is related to covered Surgery or Medical Care.

Your coverage also includes benefits for certain Diagnostic Service when you receive it as an Outpatient. This service consists of surgical pathology and x-rays if they are the initial x-rays done in connection with the initial correction of fractures or complete dislocations.

In addition to a Physician, these services will be covered when rendered by a Dentist or Podiatrist in connection with covered Surgery.

Mammograms

Pap Smear Test—Benefits will be provided for an annual routine cervical smear or Pap smear test for females. Benefits for routine cervical smears or Pap smears will be provided at the same payment level as Outpatient Diagnostic Service.

Prostate Test and Digital Rectal Examination—Benefits will be provided for an annual routine prostate-specific antigen test and digital rectal examination for males.

Ovarian Cancer Screening—Benefits will be provided for annual ovarian cancer screening for females using CA-125 serum tumor marker testing, transvaginal ultrasound, and pelvic examination.

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

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

Electroconvulsive Therapy

Radiation Therapy Treatments

Chemotherapy—however, Outpatient Chemotherapy will not include benefits for oral Chemotherapy and subcutaneous and intramuscular injections.

Emergency Accident Care—Treatment must occur within 72 hours of the accident or as soon as reasonably possible.

Emergency Medical Care

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.

Mastectomy-Related Services

Benefits for Covered Services related to mastectomies are the same as for any other condition. Mastectomy-related Covered Services include, but are 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. Inpatient care following a mastectomy for the length of time determined by your 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 48 hours after discharge; and
4. Prostheses and physical complications of all stages of the mastectomy including, but not limited to, lymphedemas.

[**Substance Abuse Rehabilitation Treatment**

Your benefits for Substance Abuse Rehabilitation Treatment are the same as your benefits for any other condition.] **2.0b New**

[**Mental Illness Services**

Your benefits for the diagnosis and/or treatment of a Mental Illness are the same as your benefits for any other condition. Medical Care for the treatment of a Mental Illness is eligible when rendered by (1) a Physician; (2) a Psychologist; (3) a Clinical Social Worker; (4) a Clinical Professional Counselor or (5) a Marriage and Family Therapist working within the scope of their license.] **2.0b New**

Maternity Service

Your benefits for Maternity Service are the same as your benefits for any other condition and are available whether you have Individual Coverage or Family Coverage. Benefits will also be provided for Covered Services rendered by a Certified Nurse-Midwife.

Benefits will be paid for Covered Services received in connection with both normal pregnancy and Complications of Pregnancy. As part of your maternity benefits certain services rendered to your newborn infant are also covered, even if you have Individual Coverage. These Covered Services are: a) one routine Inpatient examination as long as this examination is rendered by a Physician other than the Physician who delivered the child or administered anesthesia during delivery and b) one Inpatient hearing screening. (If the newborn child needs treatment for an illness or injury, benefits will be available for that care only if you have Family Coverage. You may apply for Family Coverage within 31 days of date of the birth. Your Family Coverage will then be effective from the date of the birth.)

[Your coverage also includes benefits for elective abortions if legal where performed.] 2.7

[**Infertility Treatment**

Benefits will be provided the same as your benefits for any other condition 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

makes 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 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 makes such treatment useless; and

— You have not undergone four completed oocyte retrievals, except that if a live birth followed a completed oocyte retrieval, two more completed oocyte retrievals shall be covered.

Benefits will also be provided for medical expenses of an oocyte or sperm donor for procedures used to retrieve oocytes or sperm and the subsequent procedure 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 that are eligible for coverage 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.

Special Limitations

Benefits will not be provided for the following:

1. 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.
2. Selected termination of an embryo; provided, however, termination will be covered where the mother's life would be in danger if all embryos were carried to full term.
3. Expenses incurred for cryo-preservation or storage of sperm, eggs or embryos, except for those procedures which use a cryo-preserved substance.
4. Non-medical costs of an egg or sperm donor.
5. Travel costs for travel within 100 miles of your home or travel costs not Medically Necessary or required by Blue Cross and Blue Shield.
6. Infertility treatments which are deemed Investigational, in writing, by the American Society for Reproductive Medicine or the American College of Obstetricians or Gynecologists.

7. Infertility treatment rendered to your dependents under age 18.

In addition to the above provisions, in-vitro fertilization, gamete intrafallopian tube transfer, zygote intrafallopian tube transfer, low tubal ovum transfer and intracytoplasmic sperm injection procedures must be performed at medical facilities that conform to the American College of Obstetricians and Gynecologists guidelines for in-vitro fertilization clinics or to the American Society for Reproductive Medicine minimal standards for programs of in-vitro fertilization.]

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.

[No benefits will be provided for [abortions][or surgical sterilization procedures].] 2.9

[Benefit Payment for Physician Services

When you receive any of the Covered Services described in this Physician Benefits Section, benefits will be provided at [50–100]% of the Usual and Customary Fee. 2.4a

[However, for Medical Care visits in a Coordinated Home Care Program and for Emergency Accident Care and Emergency Medical Care for Covered Services resulting from criminal sexual assault or abuse, benefits will be provided at 100% of the Usual and Customary Fee.] 2.4a1

[However, Medical Care visits in a Coordinated Home Care Program and Emergency Medical Care Covered Services for the examination and testing of a victim of criminal sexual assault or abuse to determine whether sexual contact occurred, and to establish the presence or absence of sexually transmitted disease or infection, will be paid at 100% of the Usual and Customary Fee.]

[However, for Medical Care visits, benefits will be limited to $[30–300] per visit, except that, for Medical Care Visits in a Coordinated Home Care Program, benefits will be provided at 100% of the Usual and Customary Fee.] 2.4a2

[Your benefits for the treatment of Mental Illness for those illnesses not classified as Serious Mental Illness and Substance Abuse Rehabilitation Treatment will be provided at the payment level specified in the TREATMENT OF MENTAL ILLNESS AND SUBSTANCE ABUSE REHABILITATION TREATMENT BENEFIT SECTION of this Certificate.] 31.0

TERMINATION OF COVERAGE

If your coverage should terminate, no benefits will be provided for any services that you receive on or after your termination date.] 2.4a

[Benefit Payment for Physician Services

The benefits for the Covered Services described in this Physician Benefit Section will be provided according to a schedule of fixed dollar allowances (or the Usual and Customary Fee, whichever is less). This schedule is generally referred to as an

"Indemnity Schedule." The Group Policy upon which this Certificate is based contains a very detailed Indemnity Schedule. In this Certificate we have listed below the allowances for some of the more common services or procedures. Please review the Indemnity Schedule of the Group Policy if a service is not listed in this Certificate.

These allowances are not intended to fix or relate to the value of Physician's (or other covered Provider's) services. However, if what you are charged is less than the scheduled allowance, the amount charged will be paid rather than the scheduled allowance.

The only type of service that will not be paid according to the scheduled allowance is Medical Care visits in a Coordinated Home Care Program. Benefits will be provided at 100% of the Usual and Customary Fee for these visits.] 2.4b

MAJOR MEDICAL BENEFIT SECTION

The purpose of your Major Medical coverage is to supplement, not duplicate, those benefits described in the other Benefit Sections of this Certificate. It provides coverage for many types of expenses that are not covered under those Benefit Sections and extends those benefits should you require long term care for a major illness or injury. This section of your Certificate explains the Covered Services under Major Medical and tells you what benefits will be paid for them.

The benefits of this section are subject to all of the terms and conditions of this Certificate.[Your benefits are also subject to the Preexisting Condition waiting period.] Please refer to the DEFINITIONS, ELIGIBILITY and EXCLUSIONS sections of this Certificate for additional information regarding any limitations and/or special conditions pertaining to your benefits. 0.569

In addition, the benefits described in this section will be provided only when you receive services on or after your Coverage Date and they are rendered upon the direction or under the direct care of your Physician. Such services must be Medically Necessary and regularly included in the Provider's charges.

[The level of benefits paid for Hospital Covered Services is generally greater when received in a Plan Hospital or other Plan facility.] 6.01

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

COVERED SERVICES

Your Major Medical coverage provides benefits for the following Covered Services:[

- Home, office and Outpatient visits—Visits made to a Physician's office or by a Physician to your home for treatment of an illness or injury.][6.1a
- Home, office and Outpatient visits—Visits made to a Physician's office or by a Physician to your home for treatment of an illness or injury (except that benefits will not be provided for visits for the treatment of Mental Illness).] 6.1b
- Consultations—Consultations that are requested by your Physician and that consist of another Physician's advice in the diagnosis or treatment of a condition which requires special skill or knowledge. Benefits are not available for any consultation done because of Hospital regulations or by a Physician who also renders Surgery or Maternity Service during the same Inpatient admission.[
- Assist at Surgery—When performed by a Physician, Dentist or Podiatrist who assists the operating surgeon in performing covered Surgery in a Hospital or Ambulatory Surgical Facility. In addition, benefits will be provided for assist at Surgery when performed by a Registered Surgical Assistant or an Advanced Practice Nurse. Benefits will also be provided for assist at Surgery performed by a Physician Assistant under the direct supervision of a Physician, Dentist or Podiatrist.][6.11
- Outpatient treatment of Mental Illness—Treatment for Mental Illness when rendered by (1) a Physician; (2) a Psychologist; (3) a Clinical Social Worker; (4) Clinical Professional Counselor or (5) a Marriage and Family Therapist working within the scope of their license.][6.12

- Outpatient Diagnostic Service—When ordered by a Physician and rendered concurrently with Surgery or Medical Care. Diagnostic Service ordered by a Dentist or Podiatrist is limited to x-rays for covered Surgery or Outpatient correction of fractures or complete dislocations and surgical pathology rendered concurrently with Surgery.][6.13
- Outpatient drugs and medicines—All drugs and medicines, except drugs used for cosmetic purposes (including, but not limited to, Retin-A/Tretinoin and Minoxidil/Rogaine) which require by law a written prescription and which are dispensed by a Pharmacy or Physician. In addition, your coverage includes benefits for insulin and insulin syringes even though a prescription may not be required by law.] 6.14
- Blood and blood components
- Allergy injections and allergy testing
- Oxygen and its administration
- Medical and surgical dressings, supplies, casts and splints
- Durable medical equipment—For example, such things as pacemakers and the rental of wheelchairs and mandibular reconstruction devices not used primarily to support dental prosthesis. Benefits will be provided for purchase of a piece of equipment if it is less expensive than renting the equipment subject to Blue Cross and Blue Shield approval.
- Prosthetic appliances—Benefits will be provided for prosthetic devices, special appliances and surgical implants required by you for an illness or injury when:

  a. they are required to replace all or part of an organ or tissue of the human body, or

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

  Benefits will also include adjustments, repair and replacements of covered prosthetic devices, special appliances and surgical implants when required because of wear or change in a patient's condition (excluding dental appliances [other than intra-oral devices used in connection with the treatment of Temporomandibular Joint Dysfunction and Related Disorders, subject to specific limitations applicable to Temporomandibular Joint Dysfunction and Related Disorders,]and replacement of cataract lenses when a prescription change is not required). 1.30
- Leg, back, arm and neck braces—When needed for conditions arising out of an illness or injury.
- Physical Therapy—Physical Therapy when rendered by a Physician or by a registered professional physical therapist under the supervision of a Physician. The therapy must be furnished under a written plan established by a Physician and regularly reviewed by the therapist and the Physician. The plan must be established before treatment is begun and must relate to the type, amount, frequency and duration of therapy and indicate the diagnosis and anticipated goals.[Benefits for Outpatient Physical Therapy will be limited to a maximum of $[100–20,000] per benefit period.] 6.42

- Private Duty Nursing Service—Benefits for Private Duty Nursing Service will be provided to you in your home only when the services are of such a nature that they cannot be provided by non-professional personnel and can only be provided by a licensed health care provider. No benefits will be provided when a nurse ordinarily resides in your home or is a member of your immediate family. Private Duty Nursing includes teaching and monitoring of complex care skills such as tracheotomy suctioning, medical equipment use and monitoring to home caregivers and is not intended to provide for long term supportive care. Benefits for Private Duty Nursing Service will not be provided due to the lack of willing or available non-professional personnel.[Your benefits for Private Duty Nursing Service will be limited to a maximum of $[100–5,000] per month.] 6.45
- Occupational Therapy—Benefits will be provided for Occupational Therapy when these services are rendered by a Physician or by a registered occupational therapist under the supervision of a Physician. This therapy must be furnished under a written plan established by a Physician and regularly reviewed by the therapist and the Physician. The plan must relate to the type, amount, frequency and duration of therapy and indicate the diagnosis and anticipated goals.[Benefits for Outpatient Occupational Therapy will be limited to a maximum of $[100–20,000] per benefit period.] 6.43
- Cardiac rehabilitation services—Benefits will be provided for cardiac rehabilitation services only in Blue Cross and Blue Shield approved programs. Benefits are available if you have a history of any of the following: acute myocardial infarction, coronary artery bypass graft Surgery, percutaneous transluminal coronary angioplasty, heart valve Surgery, heart transplantation, stable angina pectoris, compensated heart failure or transmyocardial revascularization. Benefits will be limited to a maximum of 36 Outpatient treatment sessions within a six month period.
- Speech Therapy—Benefits will be provided for Speech Therapy when these services are rendered by a licensed speech therapist or speech therapist certified by the American Speech and Hearing Association. Inpatient Speech Therapy benefits will be provided only if Speech Therapy is not the only reason for an admission.[Outpatient Speech Therapy benefits will be limited to a maximum of $[100–20,000] per benefit period. However, benefits will be provided for an additional [20–365] visits for Speech Therapy for treatment of pervasive developmental disorders.] 6.44
- Chemotherapy[
- Substance Abuse Rehabilitation Treatment—Your benefits for Substance Abuse Rehabilitation Treatment are the same as your benefits for any other condition. In addition, benefits will be provided if Covered Services are rendered by a Substance Abuse Treatment Facility. Substance Abuse Rehabilitation Treatment Covered Services rendered in a program that does not have a written agreement with Blue Cross and Blue Shield or in a Non-Plan Provider facility will be paid at the Non-Plan Provider facility payment level.][**Revised** 6.60
- Mental Illness Services—Your benefits for the diagnosis and/or treatment of a Mental Illness are the same as your benefits for any other condition. Medical Care for the treatment of a Mental Illness is eligible when rendered by (1) a Phy-

sician; (2) a Psychologist; (3) a Clinical Social Worker; (4) a Clinical Professional Counselor or (5) a Marriage and Family Therapist working within the scope of their license.]

New

- Substance Abuse Rehabilitation Treatment—Benefits for all the services previously described are also available for Substance Abuse Rehabilitation Treatment if these services are rendered by a Hospital or Substance Abuse Treatment Facility. Benefits for Substance Abuse Rehabilitation Treatment in a program that has a written agreement with Blue Cross and Blue Shield will be provided at the Plan Hospital payment level described later in this benefit section. Benefits for Substance Abuse Rehabilitation Treatment in a program that does not have a written agreement with Blue Cross and Blue Shield or in a Non-Plan Substance Abuse Treatment Facility will be provided at the Non-Plan Hospital payment level described later in this benefit section.][6.61
- Ambulance Transportation—Benefits will not be provided for long distance trips or use of an ambulance only because it is more convenient than other transportation.] 6.15
- Dental accident care—Dental services rendered by a Dentist or Physician which are required as the result of an accidental injury to the jaws, teeth, mouth or face.
- Chiropractic and osteopathic manipulations—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.
- Optometric service—Benefits will be provided for services which may be legally rendered by an Optometrist, provided that benefits would have been provided had such services been rendered by a Physician.[
- Christian Science Services—Spiritual treatment of an illness or injury when rendered by a qualified Christian Science Practitioner (one who is listed in the Christian Science Journal at the time services are rendered) or an accredited Christian Science Sanitorium (one that is certified by the Mother Church in Boston at the time services are rendered).] 6.17

[In addition to the Covered Services described above, all of the Hospital and Physician services that have been described in the other Benefit Sections of this Certificate are also considered Covered Services under your Major Medical benefits. However, your Major Medical benefits go into effect for those services only after you have exhausted all of your benefits for those services under those other Benefit Sections. For example, if you were to use all of your Hospital days, Major Medical would provide benefits for the additional days that you were in the Hospital. However, Major Medical will not cover expenses not paid under those other Benefit Sections because of any deductibles or co-payment amounts that are applicable. 6.18a

[The only exception to this provision is that those Covered Services described in the Dental Benefit Section are not eligible under Major Medical unless they are specifically stated in this section.]] 6.181a

[In addition to the Covered Services described above, all of the Hospital and Physician services that have been described in the other Benefit Sections of this Certificate

are also considered Covered Services under your Major Medical Benefit Section. However, those services are only eligible under Major Medical as follows:

— Major Medical will provide benefits for the Covered Services described in those other Benefit Sections if you have exhausted all of your benefits for those services under those other Benefit Sections. For example, if you were to use all of your Hospital days, Major Medical would provide benefits toward charges for the additional days that you were in the Hospital.

— Major Medical will provide benefits for expenses that remain unpaid under those other Benefit Sections because of any deductibles, copayment amounts or dollar maximums that are applicable under those Benefit Sections. However, expenses that exceed the Eligible Charge or Usual and Customary Fee are not included in such expense. 6.18b

[The only exception to this provision is that those Covered Services described in the Dental Benefit Section are not eligible under Major Medical unless they are specifically stated in this section.]] 6.181b

[In addition to the Covered Services described above, all of the Hospital and Physician services that have been described in the other Benefit Sections of this Certificate are also considered Covered Services under your Major Medical Benefit Section. However, those services are only eligible under Major Medical as follows:

— Major Medical will provide benefits for the services described in those other Benefit Sections if you exhausted all of your benefits for those services under those other sections. For example, if you were to use all of your Hospital days, Major Medical would provide benefits toward charges for the additional days that you were in the Hospital.

— Major Medical will provide benefits for expenses for the services described in the Physician Benefit Section that remain unpaid under that section because of any deductibles, co-payment amounts or dollar maximums. However, this does not mean expenses that exceed the Usual and Customary Fee. Also, if your Hospital benefits are subject to any deductibles or copayment amounts, those expenses are not eligible under Major Medical.]] 6.18c

[The only exception to this provision is that those Covered Services described in the Dental Benefit Section are not eligible under Major Medical unless they are specifically stated in this section.]] 6.181c

BENEFIT PAYMENT FOR MAJOR MEDICAL COVERED SERVICES

In determining the benefit payment under Major Medical Covered Services, there are several different provisions that apply. These are as follows:

Benefit Period

Your Major Medical benefit period is a period of one year which begins on [Month Day] of each year. When you first enroll under this coverage, your first benefit period begins on your Coverage Date, and ends on the first [Month Day] following that date. 6.21

[**Deductible**

Each benefit period you must satisfy a $[100–20,000] deductible. In other words, after you have expenses for more than $[100–20,000] of Covered Services in a benefit period, your benefits will begin. 6.22

[If you have any expenses during the last three months of a benefit period which were or could have been applied to that benefit period's deductible, these expenses will also count as credit toward the deductible of the next benefit period.] 6.21a

[Should two or more members of your family ever receive Covered Services as a result of injuries received in the same accident, only one deductible will be applied against those Covered Services.] 6.23

[When your Group initially purchases this Major Medical coverage the people who were members of the Group at that time are entitled to a special credit toward their deductible of the first benefit period. This special credit applies to expenses incurred for Covered Services within the prior contract's benefit period, if not complete. Such expenses can be applied toward the deductible of the first benefit period under this coverage. However, this is only true if your Group had Major Medical type coverage immediately prior to purchasing this coverage.] 6.24

[**Family Deductible**

If you have Family Coverage and [2,3] members of your family have each satisfied their deductible, it will not be necessary for anyone else in your family to meet a deductible in that benefit period. That is, for the rest of that benefit period, no other family members will be required to meet a deductible before receiving Major Medical benefits.

[In any case, should two or more members of your family ever receive Covered Services as a result of injuries received in the same accident, only one deductible will be applied against those Covered Services.]]] 6.25

Benefit Payment Level

[After you satisfy your deductible,][50–100]% of the Eligible Charge or Usual and Customary Fee will be paid for your Major Medical Covered Services unless otherwise specified in this Certificate. 6.26

[In the case of private room charges, benefits for that room will be provided at [50–100]% of the Plan Hospital's rate for its most common type of room with two or more beds plus an additional $[5–500] per day.] 6.27

[Your benefits for the treatment of Mental Illness for those illnesses not classified as Serious Mental Illness and Substance Abuse Rehabilitation Treatment will be provided at the payment level specified in the TREATMENT OF MENTAL ILLNESS AND SUBSTANCE ABUSE REHABILITATION TREATMENT BENEFIT SECTION of this Certificate.] 31.0

[For services received from a Non-Plan Hospital, Non-Plan Skilled Nursing Facility, Non-Plan Coordinated Home Care Program, or Non-Plan Dialysis Facility, payment will be 50% of the Eligible Charge.] 6.261

[For services received from a Non-Plan Hospital, Non-Plan Skilled Nursing Facility, Non-Plan Coordinated Home Care Program, or Non-Plan Dialysis Facility, payment will be 80% of the amount you would have received had these services been received from Plan Providers.]] 6.262

[OUT-OF-POCKET EXPENSE LIMIT

If, during one benefit period, your out-of-pocket expense (the amount remaining unpaid after Major Medical has made payment) equals $[100–20,000], any additional eligible Claims (except for those Covered Services specifically excluded below) during that benefit period will be paid in full up to the Eligible Charge or Usual and Customary Fee. 6.641

This $[100–20,000] may be reached by:[

- the Major Medical deductible] 0.6411a
- the payments for which you are responsible after Major Medical benefits have been provided[
- and any unreimbursed expenses incurred for Major Medical Covered Services within your prior contract's benefit period, if not completed.] 0.6412a

The following expenses for Covered Services cannot be applied to the out-of-pocket expense limit and will not be paid at 100% of the Eligible Charge or Usual and Customary Fee when your out-of-pocket expense limit is reached:[

- the Major Medical deductible] 0.6411b
- charges that exceed the Eligible Charge or Usual and Customary Fee[
- charges for Covered Services which have a separate dollar maximum specifically mentioned in this Certificate][
- charges for Covered Services for treatment of Mental Illness for those illnesses not classified as Serious Mental Illness and Substance Abuse Rehabilitation Treatment][
- charges for Outpatient prescription drugs][0.6413
- Copayments resulting from non-compliance with the provisions of [the Medical Services Advisory Program][Utilization Review Program][and/or][the Blue Cross and Blue Shield Mental Health Unit]][0.6415
- and any unreimbursed expenses incurred for Comprehensive Major Medical Covered Services within your prior contract's benefit period, if not completed.] 0.6412b

[If you have Family Coverage and [2,3] members of your family have reached their out-of-pocket expense limit during one benefit period, then, for the remainder of that benefit period, all other family members will have their Major Medical benefits for Covered Services (except for those Covered Services specifically excluded above) provided at 100% of the Eligible Charge or Usual and Customary Fee.] 6.29a

[If you have Family Coverage and your expenses as described above equal $[200–60,000] during one benefit period, then, for the rest of the benefit period, all other family members will have benefits for eligible Covered Services (except for those Covered Services specifically excluded above) provided at 100% of the Eligible

Charge or Usual and Customary Fee. A member may not apply more than the individual out-of-pocket expense limit toward this amount.] 6.29b

[Benefit Payment for Outpatient treatment of Mental Illness and Substance Abuse Rehabilitation Treatment

[Benefits for Outpatient treatment of Serious Mental Illness will be provided at the Hospital and Physician payment levels described in the Hospital and Physician Benefit Sections of this Certificate. 6.31a

Benefits for Outpatient treatment of Mental Illness for those illnesses not classified as Serious Mental Illness will be provided at [50–100]% of the Eligible Charge or at [50–100]% of the Usual and Customary Fee[after you have met your deductible]. 6.31a

Benefits for Outpatient Substance Abuse Rehabilitation Treatment (in a program that has a written agreement with Blue Cross and Blue Shield) will be provided at [50–100]% of the Eligible Charge or at [50–100]% of the Usual and Customary Fee[after you have met your deductible]. Benefits will be provided for Outpatient Substance Abuse Rehabilitation Treatment in a program that does not have a written agreement with Blue Cross and Blue Shield or in a Non-Plan facility at the same level as payment for Non-Plan Hospital Services.] 6.31a

[Benefits for Outpatient treatment of Mental Illness for those illnesses not classified as Serious Mental Illness will be provided at [50–100]% of the Eligible Charge or at [50–100]% of the Usual and Customary Fee for the first [5–365] visits per benefit period after you have met your deductible, thereafter benefits will be provided at 50% of the Eligible Charge or at 50% of the Usual and Customary Fee. 6.31b

Benefits for Outpatient Substance Abuse Rehabilitation Treatment (in a program that has a written agreement with Blue Cross and Blue Shield) will be provided at [50–100]% of the Eligible Charge or at [50–100]% of the Usual and Customary Fee for the first [5–365] visits per benefit period after you have met your deductible, thereafter benefits will be provided at 50% of the Eligible Charge or at 50% of the Usual and Customary Fee. Benefits will be provided for Outpatient Substance Abuse Rehabilitation Treatment in a program that does not have a written agreement with Blue Cross and Blue Shield or in a Non-Plan facility at the same level as payment for Non-Plan Hospital Services.] 6.31b

[Benefit Maximum for Outpatient treatment of Mental Illness and Substance Abuse Rehabilitation Treatment 6.32

[Your benefits for the Outpatient treatment of Mental Illness for those illnesses not classified as Serious Mental Illness and Outpatient Substance Abuse Rehabilitation Treatment are limited to a combined maximum of $[500–100,000] per benefit period.] 6.32a

[Your benefits for Outpatient treatment of Mental Illness for those illnesses not classified as Serious Mental Illness and Outpatient Substance Abuse Rehabilitation Treatment are limited to a combined maximum of [5–365] visits per benefit period.] 6.32b

[Your benefits for Outpatient treatment of Serious Mental Illness are limited to a maximum of [60–365] visits per benefit period.] 6.32d

[Your benefits for Outpatient treatment of Mental Illness for those illnesses not classified as Serious Mental Illness are limited to a maximum of [5–365] visits per benefit period.] 6.32c

[Your benefits for Outpatient Substance Abuse Rehabilitation Treatment are limited to a maximum of [5–365] visits per benefit period.] 6.32c

[You are entitled to a combined lifetime maximum of [10–1,000] Outpatient visits for Outpatient treatment of Mental Illness for those illnesses not classified as Serious Mental Illness and Substance Abuse Rehabilitation Treatment.] 6.33a

[A combined lifetime maximum of $[500–750,000] will apply to benefits for Outpatient treatment of Mental Illness for those illnesses not classified as Serious Mental Illness and/or Substance Abuse Rehabilitation Treatment.]] 6.33b

[None of the charges for Outpatient treatment of Mental Illness for those illnesses not classified as Serious Mental Illness will be included in the calculation of your out-of-pocket expenses for Major Medical Covered Services. (See Benefit Payment Level).]] 6.31

LIFETIME MAXIMUM

[The total maximum amount of Major Medical benefits to which you are entitled is $. This is an individual maximum. There is no family maximum.]

[As you use your Major Medical benefits, a certain amount will automatically be restored to your lifetime maximum each benefit period. This amount will be $[500–100,000] or the amount you have received in benefits that benefit period, whichever is less.] 6.41a

[Your Major Medical benefits are not subject to a lifetime maximum. The total dollar amount that will be paid in benefits for you is unlimited.] 6.41b

EXTENSION OF BENEFITS IN CASE OF TERMINATION

If you are receiving Major Medical benefits for a specific illness or injury at the time your coverage under this Certificate is terminated, your Major Medical coverage for Major Medical Covered Services related to that illness or injury will continue for 12 months after the date of termination only if:

1. you are Totally Disabled at the time you receive such Major Medical Covered Services, and
2. you are not eligible under any other group coverage or program that replaces the coverage under this Benefit Section of your Certificate.

Your benefits will be paid like any other Major Medical benefit payment and will be computed as if your other coverage under this Certificate was still in effect.

MAJOR MEDICAL BENEFIT SECTION

Your health care benefit program is a Comprehensive Major Medical Program. Your coverage will help you pay for a wide range of Hospital and Physician services as well as many other types of health care services. This section of your Certificate explains the services which are covered (that is, Covered Services) and the benefits that will be provided for them.

The benefits of this section are subject to all of the terms and conditions of this Certificate.[Your benefits are also subject to the Preexisting Condition waiting period.] Please refer to the DEFINITIONS, ELIGIBILITY and EXCLUSIONS sections of this Certificate for additional information regarding any limitations and/or special conditions pertaining to your benefits. 0.564

In addition, the benefits described in this section will be provided only when you receive services on or after your Coverage Date and they are rendered upon the direction or under the direct care of your Physician. Such services must be Medically Necessary and regularly included in the Provider's charges.

[The level of benefits paid for Hospital Covered Services is generally greater when received in a Plan Hospital or other Plan facility.] 6.05

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

COVERED SERVICES

Inpatient Hospital Services

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

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

Skilled Nursing Facility Care

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

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

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.

[Each time you are admitted to a Skilled Nursing Facility, you are entitled to benefits for [5–365] days of care.] 6.961a

[You are entitled to benefits for [5–365] days of care in a Skilled Nursing Facility per benefit period.] 6.961b

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

Preadmission Testing

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

[Partial Hospitalization Treatment Program

[You must be admitted to this program within 72 hours of discharge from a covered Inpatient Hospital admission.]Benefits are available for this program only if it is a Blue Cross and Blue Shield approved program. No benefits will be provided for services received in a Partial Hospitalization Treatment Program which has not been approved by Blue Cross and Blue Shield.] 6.06

Coordinated Home Care Program

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

[Each time you are admitted to a Coordinated Home Care Program, you are entitled to benefits for [5–365] visits.] 6.971a

[You are entitled to benefits for [5–365] visits in a Coordinated Home Care Program per benefit period.] 6.971b

Surgery

Benefits are available for Surgery performed by a Physician, Dentist or Podiatrist. If the Surgery is performed in a Hospital or an Ambulatory Surgical Facility, these charges are also eligible. For services performed by a Dentist or Podiatrist, benefits are limited to those procedures which may be legally rendered by them and which would be payable under this Certificate had they been performed by a Physician. Benefits for oral Surgery are limited to the services listed below.

Oral Surgery

Benefits for Surgery performed by a Dentist are limited to the following procedures:[

1. excision of tumors or cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth;][6.07b
1. surgical removal of *complete* bony impacted teeth; 6.07a
2. excision of tumors or cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth;]
3. surgical procedures to correct accidental injuries of the jaws, cheeks, lips, tongue, roof and floor of the mouth;

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.

In addition to surgical procedures, your coverage also includes benefits for the following Surgery related services:

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

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

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

[Additional Surgical Opinion

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

6.551

6.55 6.55a 6.55b

Medical Care

Benefits are available for Medical Care visits when:

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

[**Psychiatric Care**

Benefits for all of the Covered Services previously described in this Certificate are available for the diagnosis and/or treatment of a Mental Illness. Medical Care for the treatment of a Mental Illness is eligible when rendered by (1) a Physician; (2) a Psychologist; (3) a Clinical Social Worker; (4) a Clinical Professional Counselor or (5) a Marriage and Family Therapist working within the scope of their license.]

[**Mental Illness Services**

Your benefit for the diagnosis and/or treatment of a Mental Illness are the same as your benefits for any other condition. Medical Care for the treatment of a Mental Illness is eligible when rendered by (1) a Physician; (2) a Psychologist; (3) a Clinical Social Worker; (4) a Clinical Professional Counselor or (5) a Marriage and Family Therapist working within the scope of their license.]

6.8a2 MHP 10/3/09 – 7/1/10

[**Mental Illness and Substance Abuse Services**

Benefits for all of the Covered Services described in this Certificate are available for the diagnosis and/or treatment of a Mental Illness and/or Substance Abuse disorders. Medical Care for the treatment of a Mental Illness is eligible when rendered by a Behavioral Health Practitioner working within the scope of their license. Medical Care for the treatment of Substance Abuse disorders is eligible when rendered by a Behavioral Health Practitioner working within the scope of their license in a Substance Abuse Treatment Facility.]

6.8a1 Revised – MHP Final Regs 7/1/10 & after

[**Chronic Condition Management**

Benefits will be provided for services for the management of prescription drugs prescribed as part of psychiatric care, including the prescription, use and review of medication with no more than minimal medical psychotherapy.]

6.83b

[Benefits will be provided for services for the management of prescription drugs prescribed as part of Mental Illness services, including the prescription, use and review of medication with no more than minimal medical psychotherapy.]

Not coded

Consultations

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

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.

[Infertility Treatment

Benefits will be provided the same as your benefits for any other condition 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 that a medical condition exists that makes 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; or, efforts to conceive as a result of one year of medically based and supervised methods of conception, including artificial insemination, have failed and are not likely to lead to a successful pregnancy. **Revised**

Unprotected sexual intercourse means sexual union between a male and 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 and includes appropriate measures to ensure the health and safety of sexual partners. **Revised**

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 makes such treatment useless; and

— You have not undergone four completed oocyte retrievals, except that if a live birth followed a completed oocyte retrieval, two more completed oocyte retrievals shall be covered.

Benefits will also be provided for medical expenses of an oocyte or sperm donor for procedures used to retrieve oocytes or sperm and the subsequent procedure 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 that are eligible for coverage under this Certificate in your lifetime is six. 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. **Revised**

Special Limitations

Benefits will not be provided for the following:

a. 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.

b. Selected termination of an embryo; provided, however, termination will be covered where the mother's life would be in danger if all embryos were carried to full term.

c. Expenses incurred for cryo-preservation or storage of sperm, eggs or embryos, except for those procedures which use a cryo-preserved substance.

d. Non-medical costs of an egg or sperm donor.

e. Travel costs for travel within 100 miles of your home or travel costs not Medically Necessary or required by Blue Cross and Blue Shield.

f. Infertility treatments which are deemed Investigational, in writing, by the American Society for Reproductive Medicine or the American College of Obstetricians or Gynecologists.

g. Infertility treatment rendered to your dependents under age 18.

In addition to the above provisions, in-vitro fertilization, gamete intrafallopian tube transfer, zygote intrafallopian tube transfer, low tubal ovum transfer and intracytoplasmic sperm injection procedures must be performed at medical facilities that conform to the American College of Obstetricians and Gynecologists guidelines for in-vitro fertilization clinics or to the American Society for Reproductive Medicine minimal standards for programs of in-vitro fertilization.]

[**Well Child Care**

Benefits will be provided for Covered Services rendered by a Physician to children under age [one–21], even though they are not ill. Benefits will be limited to the following services: 6.53a

1. immunizations[for children under age [one–21]]; 6.533
2. physical examinations;
3. routine diagnostic tests.

Benefits for well child care will be provided at [50–100]% of the Eligible Charge or Usual and Customary Fee[whether you have met your deductible][after you have met your deductible]. 6.534 6.534a 6.534b

[Benefits for well child care will be limited to a maximum of $[100–5,000] per benefit period.[Benefits for the human papillomavirus vaccine are not subject to the well child care benefit maximum.]] 6.531 **Revised**

[**Wellness Care**

[Benefits will be provided for Covered Services rendered to persons age [one–21] and over, even though you are not ill. Benefits will be limited to the following services:] 6.53b2

[Benefits will be provided for Covered Services rendered to you, even though you are not ill. Benefits will be limited to the following services:] 6.53b3

1. immunizations[for children under age [one–21]]; 6.537
2. routine physical examinations[– [one, 2] per benefit period]; 6.535
3. routine gynecological examinations[– [one, 2] per benefit period]; 6.53b1 6.53b11

4. routine diagnostic tests (other than routine mammograms), [ordered or received on the same day as the examination]. Benefits will be provided for routine mammograms at the benefit payment level described under the Benefit Payment for Routine Mammograms provision. 6.538 **Revised**

5. [routine vision examinations[– [one, 2] per benefit period];] **New**

Benefits for wellness care will be provided at [50–100]% of the Eligible Charge or Usual and Customary Fee[whether you have met your deductible][after you have met your deductible]. 6.536a 6.536b 6.536

[Benefits for wellness care will be limited to a maximum of $[100–5,000] per benefit period. 6.532

[The following Covered Services are not subject to the wellness care benefit maximum: Pap smear test, prostate test and digital rectal examination, colorectal cancer screening, ovarian cancer screening, clinical breast examination, human papillomavirus vaccine and shingles vaccine.] 6.532 6.53b **Revised**

Diagnostic Service

Benefits will be provided for Diagnostic Service when it is ordered by a Physician, whether it is rendered to you as an Inpatient or an Outpatient.

In addition, benefits will be provided for certain Diagnostic Service when ordered by a Dentist or Podiatrist. This Diagnostic Service consists of (1) x-rays rendered in connection with covered Inpatient Surgery, (2) x-rays rendered in connection with the Outpatient correction of fractures or complete dislocations and (3) surgical pathology rendered in connection with covered Surgery.

Clinical Breast Examinations—Benefits will be provided for clinical breast examinations when performed by a Physician, Advanced Practice Nurse or a Physician Assistant working under the direct supervision of a Physician. [Benefits for clinical breast examinations will be provided at the benefit payment level described in the Wellness Care provision of this Certificate.] **New**

Mammograms[—Benefits for routine mammograms will be provided at the benefit payment level described under the Benefit Payment for Routine Mammograms provision. Benefits for mammograms, other than routine, will be provided at the same payment level as Outpatient Diagnostic Service.] 6.53b **Revised**

Pap Smear Test—Benefits will be provided for an annual routine cervical smear or Pap smear test for females[at the benefit payment level described in the Wellness Care provision of this Certificate]. 6.53b

Human Papillomavirus Vaccine—Benefits will be provided for a human papillomavirus (HPV) vaccine approved by the federal Food and Drug Administration.[Benefits will be provided at the benefit payment level for immunizations described in the Well Child Care provision of this Certificate for children under age [one–21].][Benefits will be provided at the benefit payment level for immunizations described in the Wellness Care provision of this Certificate[for persons age [one–21] and over].][Benefits will be provided at the benefit payment level for immunizations described in either the Wellness Care provision or the Well **New** 6.5HPVa 6.5HPVb

Child Care provision of this Certificate, whichever applies to you.][Benefits for the human papillomavirus vaccine are not subject to the well child care benefit maximum.] 6.5HPVc

Shingles Vaccine—Benefits will be provided for a shingles vaccine approved by the federal Food and Drug Administration [at the benefit payment level described in the Wellness Care provision of this Certificate]. **New**

Prostate Test and Digital Rectal Examination—Benefits will be provided for an annual routine prostate-specific antigen test and digital rectal examination for males[at the benefit payment level described in the Wellness Care provision of this Certificate]. 6.53b

Ovarian Cancer Screening—Benefits will be provided for annual ovarian cancer screening for females using CA-125 serum tumor marker testing, transvaginal ultrasound, and pelvic examination[at the benefit payment level described in the Wellness Care provision of this Certificate]. 6.53b

Colorectal Cancer Screening

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

[Benefits for colorectal cancer screening will be provided at the benefit payment level described in the Wellness Care provision of this Certificate. Benefits for surgical procedures, such as colonoscopy and sigmoidoscopy, are not provided at the Wellness Care payment level. Such procedure will be provided at the benefit payment level for Surgery described in this Certificate.] 6.53b

[Benefits for colorectal cancer screening, including routine colonoscopy and sigmoidoscopy, will be provided at the benefit payment level described in the Wellness Care provision of this Certificate.] **New 9/09**

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

Emergency Accident Care—Treatment must occur within 72 hours of the accident or as soon as reasonably possible.

Emergency Medical Care

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.

[No benefits will be provided for [abortions][or surgical sterilization procedures].] 6.51 6.511 6.512

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

[**Nutritional Counseling**—Benefits will be provided for nutritional counseling[, limited to a maximum of [$[100–5,000]][[one–18] visits] per benefit period].] **New**

[**Routine Vision Examination**—Benefits will be provided for [one, 2]routine vision examination[(s)][, limited to a maximum of [$[30–600]][per benefit period].] **New**

Other Covered Services

Your coverage includes benefits for the following services, whether performed on an Inpatient or Outpatient basis, as long as these services are rendered by a Physician or a Hospital, unless otherwise specified:

1. Radiation therapy
2. Chemotherapy
3. Renal dialysis treatments—Benefits will be provided if these treatments are rendered in a Hospital, a Dialysis Facility or in your home under the supervision of a Hospital or Dialysis Facility.[
4. Electroconvulsive therapy]
5. Physical Therapy—Benefits will be provided when services are rendered by a Physician or by a registered professional physical therapist under the supervision of a Physician. The therapy must be furnished under a written plan established by a Physician and regularly reviewed by the therapist and the Physician. The plan must be established before treatment is begun and must relate to the type, amount, frequency and duration of therapy and indicate the diagnoses and anticipated goals. Benefits will also be provided for preventive or Maintenance Physical Therapy when prescribed for persons affected by multiple sclerosis.[Benefits for Outpatient Physical Therapy will be limited to a maximum of $[100–1,000] per benefit period.][Your benefits for Occupational Therapy, Physical Therapy and Speech Therapy are limited to a combined maximum of[[20–365] visits][$[1,000–60,000]] per benefit period.] **New 9/09** 6.71
6. Allergy injections and allergy testing
7. Dental accident care—Benefits will be provided for dental services rendered by a Dentist or Physician which are required as the result of an accidental injury to the jaws, teeth, mouth or face.
8. Optometric services—Benefits will be provided for services which may be legally rendered by an optometrist, provided that benefits would have been provided had such services been rendered by a Physician.
9. Cardiac rehabilitation services—Benefits will be provided for cardiac rehabilitation services only in Blue Cross and Blue Shield approved programs.

Benefits are available if you have a history of any of the following: acute myocardial infarction, coronary artery bypass graft Surgery, percutaneous transluminal coronary angioplasty, heart valve Surgery, heart transplantation, stable angina pectoris, compensated heart failure or transmyocardial revascularization. Benefits will be limited to a maximum of 36 Outpatient treatment sessions within a six month period.[

10. Outpatient drugs and medicines—Drugs and medicines, except drugs used for cosmetic purposes (including, but not limited to, Retin-A/Tretinoin and Minoxidil/Rogaine), purchased for your use as an Outpatient and dispensed by a licensed Pharmacist or Physician which require by law a written prescription. However, your coverage includes benefits for insulin and insulin syringes even though a prescription may not be required by law.] 6.52

11. Wigs—Benefits will be provided for wigs (also known as cranial prostheses) when your hair loss is due to Chemotherapy, radiation therapy or alopecia.[**New**
Benefits for wigs will be limited to [a lifetime maximum of] $[100–5,000] [per benefit period.]]

Equipment, Supplies, and Appliances

Your coverage includes benefits for the following types of equipment, supplies, and appliances as long as they are prescribed by your Physician:

1. Medical and surgical dressings, supplies, casts and splints
2. Durable medical equipment—benefits will be provided for such things as internal cardiac valves, internal pacemakers, mandibular reconstruction devices (not used primarily to support dental prosthesis), bone screws, bolts, nails, plates, and any other internal and permanent devices as reasonably approved by Blue Cross and Blue Shield. Benefits will also be provided for the rental (but not to exceed the total cost) or purchase of durable medical equipment required for temporary therapeutic use provided that this equipment is primarily and customarily used to serve a medical purpose.
3. Prosthetic appliances—benefits will be provided for prosthetic devices, special appliances and surgical implants required by you when:
   a. they are required to replace all or part of an organ or tissue of the human body, or
   b. they are required to replace all or part of the function of a non-functioning or malfunctioning organ or tissue.

   Benefits will also include adjustments, repair and replacements of covered prosthetic devices, special appliances and surgical implants when required because of wear or change in a patient's condition (excluding dental appliances [other than intra-oral devices used in connection with the treatment of Temporomandibular Joint Dysfunction and Related Disorders, subject to specific limitations applicable to Temporomandibular Joint Dysfunction and Related Disorders,]and replacement of cataract lenses when a prescription change is not required).[6.78
4. Orthotic Devices—benefits will be provided for a supportive device for the body or a part of the body, head, neck or extremities, including but not limited to, leg, back, arm and neck braces. In addition, benefits will be provided for ad-

justments, repairs or replacement of the device because of a change in your physical condition, as Medically Necessary. However, benefits will not be provided for foot orthotics defined as any in-shoe device designed to support the structural components of the foot during weight-bearing activities.] New

5. Leg, back, arm and neck braces No longer used
6. Oxygen and its administration
7. Blood and blood components

Private Duty Nursing Service

Benefits for Private Duty Nursing Service will be provided to you in your home only when the services are of such a nature that they cannot be provided by non-professional personnel and can only be provided by a licensed health care provider. No benefits will be provided when a nurse ordinarily resides in your home or is a member of your immediate family. Private Duty Nursing includes teaching and monitoring of complex care skills such as tracheotomy suctioning, medical equipment use and monitoring to home caregivers and is not intended to provide for long term supportive care. Benefits for Private Duty Nursing Service will not be provided due to the lack of willing or available non-professional personnel.[Your benefits for Private Duty Nursing Service will be limited to a maximum of $[100–1,000] per [month][benefit period].] 6.76 6.76a 6.76b

Ambulance Transportation

Benefits will not be provided for long distance trips or for use of an ambulance because it is more convenient than other transportation.

Chiropractic and Osteopathic Manipulation

Benefits will be provided for manipulation or adjustment of osseous or articular structures, commonly referred to as chiropractic and osteopathic manipulation, when performed by a person licensed to perform such procedures.[Your benefits for chiropractic and osteopathic manipulation will be limited to a maximum of $[100–1,000] per benefit period.] 6.79

[**Acupuncture**—Benefits will be provided for acupuncture[, limited to a maximum of [$[100–1,000]][[5–365] visits] per benefit period].] **New**

[**Naprapathic Service**

Benefits will be provided for Naprapathic Services when rendered by a Naprapath.[Benefits for Naprapathic Services will be limited to a maximum of $[200–60,000] per benefit period.]] 6.98

[**Christian Science Services**

Your coverage includes benefits for spiritual treatment of an illness or injury when rendered by a qualified Christian Science Practitioner (one who is listed in the Christian Science Journal at the time services are rendered) or an accredited Christian Science Sanitorium (one that is certified by the Mother Church in Boston at the time services are rendered).] 6.54

Special Conditions

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

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

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

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

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

   Benefits will be provided for:

   — Inpatient and Outpatient Covered Services related to the transplant Surgery.

   — the evaluation, preparation and delivery of the donor organ.

   — the removal of the organ from the donor.

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

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

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

   — If 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 [30–200] miles from the Hospital where the transplant will be performed.[6.75

- You and your companion are each entitled to benefits for lodging and meals up to a combined maximum of $[100–5,000] per day.][6.752a
- You and your companion are each entitled to benefits for lodging up to a combined maximum of $[100–5,000] per day.][6.752b
- Benefits for transportation, lodging and meals are limited to a maximum of $[1,000–30,000] per transplant.[6.753a
- Benefits for transportation, lodging and meals are limited to a lifetime maximum of $[1,000–30,000].] 6.753b

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

- Cardiac rehabilitation services when not provided to the transplant recipient immediately following discharge from a Hospital for transplant Surgery.
- Travel time and related expenses required by a Provider.
- Drugs which do not have approval of the Food and Drug Administration.
- Storage fees.
- Services provided to any individual who is not the recipient or actual donor, unless otherwise specified in this provision.

[Your benefits for heart, lung, heart/lung, liver, pancreas and pancreas/kidney transplants are subject to a lifetime maximum of $[250,000–10,000,000]. This lifetime maximum is separate from your lifetime maximum for all other benefits.] 6.751

2. Occupational Therapy—Benefits will be provided for Occupational Therapy when these services are rendered by a Physician or by a registered occupational therapist under the supervision of a Physician. This therapy must be furnished under a written plan established by a Physician and regularly reviewed by the therapist and the Physician. The plan must be established before treatment is begun and must relate to the type, amount, frequency and duration of therapy and indicate the diagnosis and anticipated goals.[Benefits for Outpatient Occupational Therapy will be limited to a maximum of $[100–1,000] per benefit period.][Your benefits for Occupational Therapy, Physical Therapy and Speech Therapy are limited to a combined maximum of [[20–365] visits][$[1,000–60,000]] per benefit period.] 6.72 **New 9/09**

3. Speech Therapy—Benefits will be provided for Speech Therapy when these services are rendered by a licensed speech therapist or speech therapist certified by the American Speech and Hearing Association. Inpatient Speech Therapy benefits will be provided only if Speech Therapy is not the only reason for an admission.[Outpatient Speech Therapy benefits will be limited to a maximum of $[100–1,000] per benefit period.][Your benefits for Occupational Therapy, **New 9/09**

Physical Therapy and Speech Therapy are limited to a combined maximum of [[20–365] visits][$[1,000–60,000]] per benefit period. However, benefits will be provided for an additional 20[20–365] visits for Speech Therapy for treatment of pervasive developmental disorders.][However, benefits will be provided for an additional [20–365] visits for Speech Therapy for treatment of pervasive developmental disorders.]

6.73

4. Substance Abuse Rehabilitation Treatment—Benefits for all of the Covered Services previously described in this Certificate are available for Substance Abuse Rehabilitation Treatment. In addition, benefits will be provided if these services are rendered by a Substance Abuse Treatment Facility. For Plan Provider benefits to be available, services must be provided in a Substance Abuse Rehabilitation Treatment program that has a written agreement with Blue Cross and Blue Shield of a Plan Hospital or a Plan Substance Abuse Treatment Facility. Benefits for Substance Abuse Rehabilitation Treatment in a program that does not have a written agreement with Blue Cross and Blue Shield or in a Non-Plan Substance Abuse Treatment Facility will be paid at the same payment level as for Non-Plan Hospital Services.][

prior to 10/3/09 or MHP does not apply

5. Substance Abuse Rehabilitation Treatment—Your benefits for Substance Abuse Rehabilitation Treatment are the same as your benefits for any other condition. In addition, benefits will be provided if Covered Services are rendered by a Substance Abuse Treatment Facility. Substance Abuse Rehabilitation Treatment Covered Services rendered in a program that does not have a written agreement with Blue Cross and Blue Shield or in a Non-Plan Provider facility will be paid at the Non-Plan Provider facility payment level.][

MHP 10/3/09 – 7/1/10

6. Substance Abuse Rehabilitation Treatment—Your benefits for Substance Abuse Rehabilitation Treatment are the same as your benefits for any other condition. In addition, benefits will be provided if these Covered Services are rendered by a Behavioral Health Practitioner in a Substance Abuse Treatment Facility. Substance Abuse Rehabilitation Treatment Covered Services rendered in a program that does not have a written agreement with Blue Cross and Blue Shield or in a Non-Plan Provider facility will be paid at the Non-Plan Provider facility payment level.][

New – MHP Final Regs 7/1/10 & after

7. Autism Spectrum Disorder(s)—Your benefits for the diagnosis and treatment of Autism Spectrum Disorder(s) are the same as your benefits for any other condition when rendered (A) by a Physician, a Psychologist, or other licensed health care Provider who has determined that such care is Medically Necessary, or (B) by a certified, registered, or licensed health care professional with expertise in treating Autism Spectrum Disorder(s) and when such care is determined to be Medically Necessary and ordered by a Physician, a Psychologist or other licensed health care Provider.

New 10/09

Treatment for Autism Spectrum Disorder(s) shall include:

— psychiatric care, including diagnostic services;

— psychological assessments and treatments;

— habilitative or rehabilitative treatments;

— therapeutic care, including behavioral Speech, Occupational and Physical Therapies that provide treatment in the following areas: a) self care and feeding, b) pragmatic, receptive and expressive language, c) cognitive functioning, d) applied behavior analysis (ABA), intervention and modification, e) motor planning and f) sensory processing.

8. Habilitative Services—Your benefits for Habilitative Services for persons with a Congenital, Genetic, or Early Acquired Disorder are the same as your benefits for any other condition if all of the following conditions are met: New Code 10/09
   — A Physician has diagnosed the Congenital, Genetic, or Early Acquired Disorder; and
   — Treatment is administered by a licensed speech–language pathologist, Audiologist, Occupational Therapist, Physical Therapist, Physician, licensed nurse, Optometrist, licensed nutritionist, Clinical Social Worker, or Psychologist upon the referral of a Physician; and
   — Treatment must be Medically Necessary and therapeutic and not Investigational.

   Congenital, Genetic, and Early Acquired Disorders may include, but are not limited to, autism or an Autism Spectrum Disorder, cerebral palsy, and other disorders resulting from early childhood illness, trauma, or injury.

9. Maternity Service—Your benefits for Maternity Service are the same as your benefits for any other condition and are available whether you have Individual Coverage or Family Coverage. Benefits will also be provided for Covered Services rendered by a Certified Nurse-Midwife. Benefits will be paid for Covered Services of this benefit section received in connection with both normal pregnancy and Complications of Pregnancy. As part of your maternity benefits certain services rendered to your newborn infant are also covered, even if you have Individual Coverage. These Covered Services are: a) the routine Inpatient Hospital nursery charges, b) one routine Inpatient examination as long as this examination is rendered by a Physician other than the Physician who delivered the child or administered anesthesia during delivery and c) one Inpatient hearing screening. (If the newborn child needs treatment for an illness, injury, congenital defect, birth abnormality or a premature birth, benefits will be available for that care from the moment of birth up to the first [31–60] days, thereafter, you must add the newborn child to your Family Coverage. You may apply for Family Coverage within 31 days of the date of the birth. Your Family Coverage will then be effective from the date of the birth.) **Revised**

   Benefits will be provided for any hospital length of stay in connection with childbirth for the mother or newborn child for no less than 48 hours following a normal vaginal delivery, or no less than 96 hours following a cesarean section. Your Provider will not be required to obtain authorization from Blue Cross and Blue Shield for prescribing a length of stay less than 48 hours (or 96 hours). 6.81a

   [Your coverage also includes benefits for elective abortions, if legal where performed.]][6.81a1

10. Complications of Pregnancy—Benefits will be paid for Covered Services received in connection with Complications of Pregnancy.][6.81b

11. Temporomandibular Joint Dysfunction and Related Disorders—Benefits for all of the Covered Services previously described in this Certificate are available for the diagnosis and treatment of Temporomandibular Joint Dysfunction and Related Disorders.[Your benefits for the diagnosis and/or treatment of Temporomandibular Joint Dysfunction and Related Disorders are limited to a lifetime maximum of $[500–100,000].] 6.78a

    [Your benefits for the diagnosis and/or treatment of Temporomandibular Joint Dysfunction and Related Disorders are limited to a benefit period maximum of $500[500–100,000].]] 6.78b 6.78

12. Routine mammograms—Benefits will be provided for routine mammograms for all women. A routine mammogram is an x-ray or digital examination of the breast for the presence of breast cancer, even if no symptoms are present. [Benefits for routine mammograms will be provided as follows: **New**

    — one baseline mammogram

    — an annual mammogram]

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

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

13. Mastectomy-Related Services—Benefits for Covered Services related to mastectomies are the same as for any other condition. Mastectomy-related Covered Services include, but are not limited to:

    a. Reconstruction of the breast on which the mastectomy has been performed;

    b. Surgery and reconstruction of the other breast to produce a symmetrical appearance;

    c. Inpatient care following a mastectomy for the length of time determined by your 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 48 hours after discharge; and

    d. Prostheses and physical complications of all stages of the mastectomy including, but not limited to, lymphedemas.

BENEFIT PAYMENT FOR MAJOR MEDICAL COVERED SERVICES

In determining benefits for your Covered Services, there are several different provisions that apply. These are as follows:

Benefit Period

Your Major Medical benefit period is a period of one year which begins on [Month Day] of each year. When you first enroll under this coverage, your first benefit period begins on your Coverage Date, and ends on the first [Month Day] following that date. 6.62

[**Deductible**

Each benefit period you must satisfy a $[100–1,000] deductible. In other words, after you have expenses for more than $[100–1,000] of Covered Services in a benefit period, your benefits will begin. However, the deductible does not include any amount in excess of the Eligible Charge or Usual and Customary Fee.

[If you have any expenses during the last three months of a benefit period which were or could have been applied to that benefit period's deductible, these expenses will also count as credit toward the deductible of the next benefit period.]] 6.62a

[**Deductible**

Each benefit period you must satisfy a $[100–1,000] Comprehensive Major Medical deductible. In other words, after you have expenses for more than $[100–1,000] of Covered Services in a benefit period, your benefits will begin. However, each time you are admitted to the Hospital, you must satisfy a $[100–5,000] Inpatient Hospital deductible. This deductible is in addition to your Comprehensive Major Medical deductible. In addition, the deductibles do not include any amount in excess of the Eligible Charge or Usual and Customary Fee. 6.62b

[If you have any expenses during the last three months of a benefit period which were or could have been applied to that benefit period's deductible, these expenses will also count as credit toward the deductible of the next benefit period.] 6.62b

[When your Group initially purchases this Major Medical coverage, the people who are members of the Group at that time are entitled to a special credit toward their deductible for the first benefit period. This special credit applies to expenses incurred for Major Medical Covered Services within the prior contract's benefit period, if not completed. Such expenses can be applied toward the deductible for the first benefit period under this coverage. However, this is only true if your Group had Major Medical type coverage immediately prior to purchasing this coverage.]] 6.621

[**Family Deductible**

[If you have Family Coverage and [2,3] members of your family have each satisfied their Comprehensive Major Medical deductible, it will not be necessary for anyone else in your family to meet a Comprehensive Major Medical deductible in that benefit period. That is, for the remainder of that benefit period, no other family members will be required to meet a Comprehensive Major Medical deductible before receiving benefits.] 6.63a

[If you have Family Coverage and your family has reached the Comprehensive Major Medical deductible amount of $[200–15,000], it will not be necessary for anyone else in your family to meet a Comprehensive Major Medical deductible in that benefit period. That is, for the remainder of that benefit period, no other family members are required to meet a Comprehensive Major Medical deductible before receiving bene-

fits. A family member may not apply more than the individual deductible amount toward the family deductible.] 6.63b

[In any case, should two or more members of your family ever receive Covered Services as a result of injuries received in the same accident, only one deductible will be applied against those Covered Services.]] 6.63

General Payment Level

[After you satisfy your deductible,][50–100]% of the Eligible Charge or Usual and Customary Fee will be paid for your Major Medical Covered Services unless otherwise specified in this Certificate. In the case of private room charges, this percentage is of the Hospital's rate for its most common type of room with two or more beds. 6.64a

[When you receive Covered Services in your Physician's office, benefits for office visits are subject to a Copayment of $[5–100] per visit.] 6.64b

[Benefits for routine vision examinations will be provided at [50–100]% of the [Usual and Customary Fee][after you have met your program deductible].][Your program deductible will not apply.] **New**

[However, Emergency Accident Care and Emergency Medical Care benefits for Covered Services resulting from criminal sexual assault or abuse will be paid at 100% of the Eligible Charge or Usual and Customary Fee whether or not you have met your deductible.] 6.642a

[However, Emergency Medical Care Covered Services for the examination and testing of a victim of criminal sexual assault or abuse to determine whether sexual contact occurred, and to establish the presence or absence of sexually transmitted disease or infection, will be paid at 100% of the Eligible Charge or Usual and Customary Fee[whether or not you have met your program deductible].[The office Copayment will not apply.]] 6.642b

[**When you receive Inpatient services in your Employer Hospital benefits will be provided at 100% of the Hospital's Eligible Charge. For Inpatient Services you receive at a Hospital other than your Employer Hospital and for all other Covered Services, benefit payment will be as described above**.] 6.643

[For Covered Services received from a Non-Plan Hospital, Non-Plan Skilled Nursing Facility, Non-Plan Coordinated Home Care Program, or Non-Plan Dialysis Facility, benefit payment will be 50% of the Eligible Charge.

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

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

In order for you to continue to receive benefits at the Plan Hospital payment level following an emergency admission to a Non-Plan Hospital, you must transfer to a Plan Hospital or other Plan Provider as soon as your condition is no longer serious.] 6.82a

[For services received from a Non-Plan Hospital, Non-Plan Skilled Nursing Facility, Non-Plan Coordinated Home Care Program, or Non-Plan Dialysis Facility, benefit payment will be 80% of the amount you would have received had these services been received from Plan Providers.] 6.82b

[OUT-OF-POCKET EXPENSE LIMIT

If, during one benefit period, your out-of-pocket expense (the amount remaining unpaid after Major Medical has made payment) equals $[100–1,000], any additional eligible Claims (except for those Covered Services specifically excluded below) during that benefit period will be paid in full up to the Eligible Charge or Usual and Customary Fee. 6.641

This $[100–1,000] may be reached by:

- [the Comprehensive Major Medical deductible] 0.6411a
- [the Inpatient Hospital admission deductible] 0.6414a
- the payments for which you are responsible after Comprehensive Major Medical benefits have been provided
- [any expenses incurred during the last 3 months of the prior benefit period which were or could have been applied to that benefit period's out-of-pocket expense limit] 0.6419
- [and any unreimbursed expenses incurred for Comprehensive Major Medical Covered Services within your prior contract's benefit period, if not completed.] 0.6412a

The following expenses for Covered Services cannot be applied to the out-of-pocket expense limit and will not be paid at 100% of the Eligible Charge or Usual and Customary Fee when your out-of-pocket expense limit is reached:

- [the Comprehensive Major Medical deductible] 0.6411b
- [the Inpatient Hospital admission deductible] 0.6414b
- charges that exceed the Eligible Charge or Usual and Customary Fee
- [charges for Covered Services which have a separate dollar maximum specifically mentioned in this Certificate] 0.6420
- [charges for Covered Services for treatment of Mental Illness for those illnesses not classified as Serious Mental Illness and Substance Abuse Rehabilitation Treatment] 0.6417
- [charges for Outpatient prescription drugs] 0.6413
- [Copayments resulting from non-compliance with the provisions of the [Medical Services Advisory][Utilization Review] Program and/or the Blue Cross and Blue Shield Mental Health Unit] 0.6415
- [the Copayment for Physician office visits] 0.6416
- [the Hospital emergency room Copayment] 6.6418

- the Coinsurance resulting from Covered Services rendered by a Non-Plan Hospital or other Non-Plan Provider for Covered Services other than Emergency Accident Care, Emergency Medical Care and Inpatient treatment during the period of time when your condition is serious
- [and any unreimbursed expenses incurred for Comprehensive Major Medical Covered Services within your prior contract's benefit period, if not completed.]] 0.6412b

[If you have Family Coverage and [2,3] members of your family have reached their out-of-pocket expense limit during one benefit period, then, for the remainder of that benefit period, all other family members will have their Major Medical benefits for Covered Services (except for those Covered Services specifically excluded above) provided at 100% of the Eligible Charge or Usual and Customary Fee.] 6.65a

[If you have Family Coverage and your expense as described above equals $[200–60,000] during one benefit period, then, for the rest of the benefit period, all other family members will have benefits for eligible Covered Services (except for those Covered Services specifically excluded above) provided at 100% of the Eligible Charge or Usual and Customary Fee. A member may not apply more than the individual out-of-pocket expense limit toward this amount.] 6.65b

[Benefit Payment for Preadmission Testing 6.644

Benefits for preadmission testing will be provided at [50–100]% of the Eligible Charge when you receive services from a Plan Provider.

[When you receive services from a Non-Plan Provider, payment will be 50% of the Eligible Charge.] 6.644a

[When you receive services from a Non-Plan Provider, payment will be 80% of the amount you would have received had you been in a Plan Provider.] 6.644b

[These benefits for preadmission testing will be provided as stated above, [whether you have met your deductible][after you have met your deductible].]] 6.6441a 6.6441b

[Benefit Payment for Coordinated Home Care Programs 6.645

Benefits for services under a Plan Coordinated Home Care Program will be provided at [50–100]% of the Eligible Charge.

[When you receive services under a Non-Plan Coordinated Home Care Program, payment will be 50% of the Eligible Charge.] 6.645a

[When you receive services under a Non-Plan Coordinated Home Care Program, payment will be 80% of the amount you would have received had you been in a Plan Coordinated Home Care Program.] 6.645b

[These benefits for services under a Coordinated Home Care Program will be provided as stated above, [whether you have met your deductible][after you have met your deductible].]] 6.6451a 6.6451b

[Benefit Payment for Outpatient Surgery Service

When you receive Outpatient Surgery Covered Services, [50–100]% of the Eligible Charge will be paid when you receive services from a Plan Hospital or Plan Ambulatory Surgical Facility. 6.77

[When you receive services from a Non-Plan Provider, payment will be 50% of the Eligible Charge.] 6.77a

[When you receive services from a Non-Plan Provider, payment will be 80% of the amount you would have received had you been in a Plan Hospital.] 6.77b

Payment for Physician Covered Services for Surgery will be [50–100]% of the Usual and Customary Fee. 6.77

[These benefits for Outpatient Surgery will be provided as stated above, [whether you have met your deductible][after you have met your deductible].]] 6.77 6.771a 6.771b

[Benefit Payment for Outpatient Diagnostic Service and Mammograms

[When you receive Outpatient Diagnostic Service and mammograms (other than routine mammograms) from a Plan Hospital, benefits will be provided at [50–100]% of the Eligible Charge [whether or not you have met your deductible][after you have met your deductible]. Benefits for routine mammograms will be provided at the benefit payment level described under the Benefit Payment for Routine Mammograms provision.] **Revised**

[If you receive these services from a Non-Plan Hospital, benefits will be provided at 50% of the Eligible Charge.] 6.69a

[When you receive services from a Non-Plan Provider, payment will be 80% of the amount you would have received had you been in a Plan Hospital.] 6.69b

[When you receive Outpatient Diagnostic Service and mammograms (other than routine mammograms) from a Physician (or laboratory), benefits will be provided at [50–100]% of the [Usual and Customary Fee] [whether or not you have met your deductible][after you have met your deductible]. Benefits for routine mammograms will be provided at the benefit payment level described under the Benefit Payment for Routine Mammograms provision.] **Revised** 6.69

[Benefits for Outpatient Diagnostic Service and mammograms will be provided as stated above, [whether you have met your deductible][after you have met your deductible].]] obsolete 6.691 6.691a 6.691b

[Benefit Payment for Routine Mammograms

Benefits for routine mammograms when received from a Plan Provider will be provided at 100% of the Eligible Charge or [Usual and Customary Fee] whether or not you have met your deductible.

Benefits for routine mammograms when received from a Non-Plan Hospital will be provided at [50–100]% of the Eligible Charge [after you have met your program deductible][and will not be subject to the program deductible]. **New**

[Benefits for routine mammograms will not be subject to any [benefit period maximum or]lifetime maximum.]

[Benefit Payment for Certain Outpatient Covered Services

Benefits for the following Outpatient Covered Services will be provided at [50–100]% of the Eligible Charge or Usual and Customary Fee when rendered in a

Plan Hospital or by a Physician[, whether or not you have met your deductible]. Non-Plan benefits will be provided at 50% of the Eligible Charge. 6.7

Surgery

Chemotherapy

Renal Dialysis Treatment

Electroconvulsive therapy

Radiation therapy] 6.7

[**Benefit Payment for Emergency Care**

If you receive Emergency Accident Care or Emergency Medical Care from a Plan or Non-Plan Provider, benefits will be provided at [50–100]% of the Eligible Charge or Usual and Customary Fee, whether or not you have met your deductible.] 6.66

[Each time you receive Covered Services in an emergency room, you will be responsible for a Copayment of $[5–100].] 6.662

[However, Emergency Accident Care and Emergency Medical Care benefits for Covered Services resulting from criminal sexual assault or abuse will be paid at 100% of the Eligible Charge or Usual and Customary Fee[whether you have met your deductible][and]will not be subject to the emergency room Copayment].] 6.661 6.662

[However, Emergency Medical Care Covered Services for the examination and testing of a victim of criminal sexual assault or abuse to determine whether sexual contact occurred, and to establish the presence or absence of sexually transmitted disease or infection, will be paid at 100% of the Eligible Charge or Usual and Customary Fee[whether or not you have met your program deductible].[The office Copayment will not apply.]]

[**Benefit Payment for Outpatient treatment of Mental Illness and Substance Abuse Rehabilitation Treatment**

Benefits for Outpatient treatment of Serious Mental Illness will be provided at the payment levels previously described in the General Payment Level provision of this Certificate for Hospital and Physician Covered Services.]

[Benefits for Outpatient treatment of Mental Illness for those illnesses not classified as Serious Mental Illness will be provided at [50–100]% of the Eligible Charge or at [50–100]% of the Usual and Customary Fee[after you have met your deductible].] 6.671a

[Benefits for Outpatient Substance Abuse Rehabilitation Treatment (in a program that has a written agreement with Blue Cross and Blue Shield) will be provided at [50–100]% of the Eligible Charge or at [50–100]% of the Usual and Customary Fee[after you have met your deductible].] 6.672a

[Benefits for Outpatient treatment of Mental Illness for those illnesses not classified as Serious Mental Illness will be provided at [50–100]% of the Eligible Charge or at [50–100]% of the Usual and Customary Fee for the first [5–365] visits per benefit period[after you have met your deductible], thereafter benefits will be provided at 50% of the Eligible Charge or at 50% of the Usual and Customary Fee.] 6.671b

[Benefits for Outpatient Substance Abuse Rehabilitation Treatment (in a program that has a written agreement with Blue Cross and Blue Shield) will be provided at [50–100]% of the Eligible Charge or at [50–100]% of the Usual and Customary Fee for the first [5–365] visits per benefit period[after you have met your deductible], thereafter benefits will be provided at 50% of the Eligible Charge or at 50% of the Usual and Customary Fee.] 6.672b

[When you receive Covered Services for the Outpatient treatment of Mental Illness for those illnesses not classified as Serious Mental Illness in a Non-Plan Provider facility, benefits will be provided at 50% of the Eligible Charge[after you have met your deductible]. 6.675a

When you receive Covered Services for Outpatient Substance Abuse Rehabilitation Treatment in a program that does not have a written agreement with Blue Cross and Blue Shield or in a Non-Plan Provider facility, benefits will be provided at 50% of the Eligible Charge[after you have met your deductible].] 6.675a

[When you receive Covered Services for the Outpatient treatment of Mental Illness for those illnesses not classified as Serious Mental Illness in a Non-Plan Provider facility, benefit payment will be 80% of the amount you would have received had these services been received from a Plan Provider. 6.675b

When you receive Covered Services for Outpatient Substance Abuse Rehabilitation Treatment in a program that does not have a written agreement with Blue Cross and Blue Shield or in a Non-Plan Provider facility, benefit payment will be 80% of the amount you would have received had these services been received from a Plan Provider.] 6.675b

[Benefit Maximum for Outpatient [treatment of Mental Illness][and][Substance Abuse Rehabilitation Treatment] 6.673

[Your benefits for Outpatient treatment of Serious Mental Illness are limited to a maximum of [35–365] visits per benefit period.] 6.673d

[Your benefits for Outpatient treatment of Mental Illness for those illnesses not classified as Serious Mental Illness and Outpatient Substance Abuse Rehabilitation Treatment are limited to a combined maximum of [5–365] visits per benefit period.] 6.673b

[Your benefits for Outpatient treatment of Mental Illness for those illnesses not classified as Serious Mental Illness are limited to a maximum of [5–365] visits per benefit period.] 6.673c

[Your benefits for Outpatient Substance Abuse Rehabilitation Treatment are limited to a maximum of [5–365] visits per benefit period.] 6.673c

[Your benefits for Outpatient Substance Abuse Rehabilitation Treatment are limited to a maximum of $[500–100,000] per benefit period.]] 6.673a

[Benefit Payment for Inpatient treatment of Mental Illness and Substance Abuse Rehabilitation Treatment

Benefits for the Inpatient treatment of Serious Mental Illness will be provided at the payment levels previously described in the General Payment Level provision of this Certificate for Hospital and Physician Covered Services.]

[Benefits for Hospital Covered Services for the Inpatient treatment of Mental Illness for those illnesses not classified as Serious Mental Illness and Inpatient Substance Abuse Rehabilitation Treatment in a program that has a written agreement with Blue Cross and Blue Shield will be provided at [50–100]% of the Eligible Charge for the first [5–365] days of each admission[after you have met your deductible], thereafter any remaining eligible Hospital charges will be paid at 50% of the Eligible Charge.] 6.674a

[Benefits for Hospital Covered Services for the Inpatient treatment of Mental Illness for those illnesses not classified as Serious Mental Illness and Inpatient Substance Abuse Rehabilitation Treatment in a program that has a written agreement with Blue Cross and Blue Shield will be provided at [50–100]% of the Eligible Charge[after you have met your deductible].] 6.674b

[When you receive Covered Services for the Inpatient treatment of Mental Illness for those illnesses not classified as Serious Mental Illness in a Non-Plan Provider facility, benefits will be provided at 50% of the Eligible Charge[after you have met your deductible].] 6.675a

[When you receive Covered Services for Inpatient Substance Abuse Rehabilitation Treatment in a program that does not have a written agreement with Blue Cross and Blue Shield or in a Non-Plan Provider facility, benefits will be provided at 50% of the Eligible Charge[after you have met your deductible].] 6.675a

[When you receive Covered Services for the Inpatient treatment of Mental Illness for those illnesses not classified as Serious Mental Illness in a Non-Plan Provider facility, benefit payment will be 80% of the amount you would have received had these services been received from a Plan Provider.] 6.675b

[When you receive Covered Services for Inpatient Substance Abuse Rehabilitation Treatment in a program that does not have a written agreement with Blue Cross and Blue Shield or in a Non-Plan Provider facility, benefit payment will be 80% of the amount you would have received had these services been received from a Plan Provider.] 6.675b

[When you receive Covered Services for the Inpatient treatment of Mental Illness for those illnesses not classified as Serious Mental Illness or Inpatient Substance Abuse Rehabilitation Treatment from a Physician, Psychologist, Clinical Social Worker, Clinical Professional Counselor or Marriage and Family Therapist benefits will be provided at [50–100]% of the Usual and Customary Fee[after you have met your deductible].]] 6.676

[Benefit Maximum for Inpatient [treatment of Mental Illness]and][Substance Abuse Rehabilitation Treatment]

[You are entitled to a maximum of [45–365] Inpatient Hospital days each benefit period for Inpatient treatment of Serious Mental Illness.] 6.677d

[You are entitled to a combined maximum of [5–365] Inpatient Hospital days each benefit period for Inpatient treatment of Mental Illness for those illnesses not classified as Serious Mental Illness and Inpatient Substance Abuse Rehabilitation Treatment.] 6.677a

[You are entitled to a maximum of [5–365] Inpatient Hospital days each benefit period for Inpatient treatment of Mental Illness for those illnesses not classified as Serious Mental Illness.] 6.677b

[You are entitled to a maximum of [5–365] Inpatient Hospital days each benefit period for Inpatient Substance Abuse Rehabilitation Treatment.] 6.677b

[Your benefits for Inpatient Substance Abuse Rehabilitation Treatment are limited to a maximum of $[500–750,000] per benefit period.]] 6.677c

[Lifetime Benefit Maximum for [treatment of Mental Illness][and][Substance Abuse Rehabilitation Treatment]

[You are entitled to a combined lifetime maximum of [10–1,000] Inpatient Hospital days for Inpatient treatment of Mental Illness for those illnesses not classified as Serious Mental Illness and Substance Abuse Rehabilitation Treatment.] 6.679

[You are entitled to a combined lifetime maximum of [10–1,000] Outpatient visits for Outpatient treatment of Mental Illness for those illnesses not classified as Serious Mental Illness and Substance Abuse Rehabilitation Treatment.] 6.680

[A lifetime maximum of $[500–750,000] will apply to benefits for Inpatient and Outpatient Substance Abuse Rehabilitation Treatment.]] 6.678 6.67

[None of the charges for the Inpatient and/or Outpatient treatment of Mental Illness for those illnesses not classified as Serious Mental Illness or Substance Abuse Rehabilitation Treatment will be included in the calculation of your out-of-pocket expenses.]

[Benefit Payment For Mental Illness, Substance Abuse Rehabilitation Treatment And Chronic Condition Management

Your benefits for the treatment of Mental Illness, Substance Abuse Rehabilitation treatment and Chronic Condition Management are determined differently than the other benefits described in this Certificate. The benefit payment for the treatment of Mental Illness, Substance Abuse Rehabilitation treatment and Chronic Condition Management will be determined at the In-Network or Out-of-Network payment level.

Prior to receiving Covered Services or, in the case of an emergency, for the treatment of Mental Illness, Substance Abuse Rehabilitation Treatment or Chronic Condition Management you must, in order to receive maximum benefits, contact the Blue Cross and Blue Shield Mental Health Unit at 1-800-851-7498. When you contact the Blue Cross and Blue Shield Mental Health Unit, you will be referred to a specific Professional Provider for treatment.

Benefits for the treatment of Mental Illness, Substance Abuse Rehabilitation Treatment and Chronic Condition Management will be provided at the In-Network payment level only if you contact the Blue Cross and Blue Shield Mental Health Unit prior to receiving Covered Services and receive Covered Services from the Professional Provider to whom you have been referred by the Blue Cross and Blue Shield Mental Health Unit.

Benefits for the treatment of Mental Illness, Substance Abuse Rehabilitation Treatment and Chronic Condition Management will be provided at the Out-of-Network payment level if you contact the Blue Cross and Blue Shield Mental Health Unit but do not receive Covered Services from the Professional Provider to whom you have been referred by the Blue Cross and Blue Shield Mental Health Unit.

If you do not contact the Blue Cross and Blue Shield Mental Health Unit prior to receiving Covered Services for the treatment of Mental Illness, Substance Abuse Rehabilitation Treatment and Chronic Condition Management, you will be responsible for the first $[100–1,000] or 50% of Claim Charges, whichever is less.] 6.83b

[**Outpatient Mental Illness Treatment**

Benefits for the Outpatient treatment of Serious Mental Illness will be provided at the payment levels previously described in the General Payment Level provision of this Certificate for Hospital and Physician Covered Services.

After you have met your deductible, benefits for Outpatient treatment of Mental Illness for those illnesses not classified as Serious Mental Illness will be provided at [50–100]% of the Eligible Charge or at [50–100]% of the Usual and Customary Fee when you receive Covered Services In-Network. 6.831

After you have met your deductible, benefits for Outpatient treatment of Mental Illness for those illnesses not classified as Serious Mental Illness will be provided at [50–100]% of the Eligible Charge or [50–100]% of the Usual and Customary Fee when you receive Covered Services Out-of-Network. 6.832

[Your benefits for Outpatient treatment of Serious Mental Illness are limited to a maximum of [60–365] visits per benefit period. However, persons age 18 and under are entitled to [60–365] visits per benefit period for the Outpatient treatment of Serious Mental Illness.] 6.8331

[Your benefits for Outpatient treatment of Mental Illness for those illnesses not classified as Serious Mental Illness are limited to a maximum of [5–365] visits per benefit period. However, persons age 18 and under are entitled to [5–365] visits per benefit period for the Outpatient treatment of Mental Illness for those illnesses not classified as Serious Mental Illness.]] 6.833

[**Outpatient Substance Abuse Rehabilitation Treatment**

After you have met your deductible, benefits for Outpatient Substance Abuse Rehabilitation Treatment will be provided at [50–100]% of the Eligible Charge or at [50–100]% of the Usual and Customary Fee when you receive Covered Services In-Network. 6.831

When you receive Covered Services (in a program that has a written agreement with Blue Cross and Blue Shield) Out-of-Network for Outpatient Substance Abuse Rehabilitation Treatment, benefits will be provided at [50–100]% of the Eligible Charge or [50–100]% of the Usual and Customary Fee after you have met your deductible. 6.832

Benefits for Out-of-Network Substance Abuse Rehabilitation Treatment in a program that does not have a written agreement with Blue Cross and Blue

Shield or in a Non-Plan Provider facility will be provided at 50% of the Eligible Charge after you have met your deductible.

[Your benefits for Outpatient Substance Abuse Rehabilitation Treatment are limited to a maximum of [5–365] visits per benefit period. However, persons age 18 and under are entitled to a maximum of [5–365] visits per benefit period for Outpatient Substance Abuse Rehabilitation Treatment.]] 6.834

[**Chronic Condition Management**

Benefits for the treatment of Chronic Condition Management will be provided at [50–100]% of the Eligible Charge or at [50–100]% of the Usual and Customary Fee when you receive Covered Services In-Network. When you receive Covered Services Out-of-Network for the treatment of Chronic Condition Management, benefits will be provided at [50–100]% of the Eligible Charge or [50–100]% of the Usual and Customary Fee after you have met your deductible.

Your benefits for the treatment of Chronic Condition Management are limited to one visit each month.] 6.835

[**Inpatient Mental Illness and Substance Abuse Rehabilitation Treatment**

Benefits for the Inpatient treatment of Serious Mental Illness will be provided at the payment levels previously described in the General Payment Level provision of this Certificate for Hospital and Physician Covered Services.

After you have met your deductible, benefits for the Inpatient treatment of Mental Illness for those illnesses not classified as Serious Mental Illness and Inpatient Substance Abuse Rehabilitation Treatment will be provided at [50–100]% of the Eligible Charge or at [50–100]% of the Usual and Customary Fee when you receive Covered Services In-Network. 6.836

After you have met your deductible, benefits for the Inpatient treatment of Mental Illness for those illnesses not classified as Serious Mental Illness and Inpatient Substance Abuse Rehabilitation Treatment (in a program that has a written agreement with Blue Cross and Blue Shield) will be provided at [50–100]% of the Eligible Charge or at [50–100]% of the Usual and Customary Fee when you receive Covered Services Out-of-Network. 6.837

When you receive Out-of-Network Covered Services for the Inpatient treatment of Mental Illness for those illnesses not classified as Serious Mental Illness or Substance Abuse Rehabilitation Treatment in a program that does not have a written agreement with Blue Cross and Blue Shield or in a Non-Plan Provider facility, benefits will be provided at 50% of the Eligible Charge after you have met your deductible.

[You are entitled to a maximum of [45–365] Inpatient Hospital days each benefit period for the Inpatient treatment of Serious Mental Illness.] 6.8381

[You are entitled to a maximum of [5–365] Inpatient Hospital days each benefit period for the Inpatient treatment of Mental Illness for those illnesses not classified as Serious Mental Illness and a maximum of [5–365] Inpatient Hospital days each benefit period for Inpatient Substance Abuse Rehabilitation Treatment. 6.838

For every two days of care in a Partial Hospitalization Psychiatric Treatment Program, one day is deducted from your Inpatient Hospital days for the treatment of Mental Illness.]] 6.838

[None of the charges for the Inpatient and/or Outpatient treatment of Mental Illness for those illnesses not classified as Serious Mental Illness or Substance Abuse Rehabilitation Treatment will be applied in satisfying your Out-of-Pocket Expense Limit as explained later in this Certificate.]

[Lifetime Maximum for [Mental Illness][and][Substance Abuse Rehabilitation Treatment]

[Your benefits for the Inpatient and Outpatient Substance Abuse Rehabilitation Treatment are limited to a combined lifetime maximum of $[500–750,000]. However, the maximum amount that will be paid for Out-of-Network Inpatient and Outpatient Substance Abuse Rehabilitation Treatment is a combined lifetime maximum of $[500–750,000].] 6.839

[A combined lifetime maximum of [30–365] Inpatient Hospital days will apply to benefits for Inpatient treatment of Mental Illness for those illnesses not classified as Serious Mental Illness and Substance Abuse Rehabilitation Treatment.] 6.840

[A combined lifetime maximum of [30–365] Outpatient visits will apply to benefits for Outpatient treatment of Mental Illness for those illnesses not classified as Serious Mental Illness and Substance Abuse Rehabilitation Treatment.]] 6.841 6.83b

LIFETIME MAXIMUM

[The total maximum amount of benefits to which you are entitled under this benefit program is $[250,000–10,000,000]. This is an individual maximum. There is no family maximum. 6.68a

[As you use your benefits, a certain amount will automatically be restored to your lifetime maximum each year. This amount will be $[500–100,000] or the amount you have received in benefits that benefit period, whichever is less.]] 6.68a1

[The total dollar amount that will be available in benefits for you is unlimited, subject to any separate dollar maximums for specific Covered Services described in this Certificate.] 6.68b

[Cumulative Benefit Maximums

All benefits payable under this Certificate are cumulative. Therefore, in calculating the benefit maximums payable for a particular Covered Service or in calculating the remaining balance under the Lifetime Maximums, Blue Cross and Blue Shield will include benefit payments under both this and/or any prior or subsequent Blue Cross and Blue Shield Certificate issued to you as an Eligible Person or a dependent of an Eligible Person under this Group.] 6.98

EXTENSION OF BENEFITS IN CASE OF TERMINATION

If you are an Inpatient at the time your coverage under this Certificate is terminated, benefits will be provided for, and limited to, the Covered Services of this Certificate which are rendered by and regularly charged for by a Hospital, Skilled Nursing Facility,[Substance Abuse Treatment Facility,][Partial Hospitalization Treatment

Program] or Coordinated Home Care Program. Benefits will be provided until you are discharged or until the end of your benefit period, whichever occurs first.

MEDICAL SUPPORT PROGRAM

(Applies to Out-of-Network Inpatient Hospital Services)

Blue Cross and Blue Shield's Medical Support Department will perform preadmission review and length of stay review for your Out-of-Network Inpatient Hospital services. The Medical Support Department is staffed primarily by registered nurses and other personnel with clinical backgrounds. The Physicians in our Medical Department are an essential part of the program.

Failure to contact the Medical Support Department or to comply with the recommendations of the Medical Support Department will result in your receiving less benefits. Please read the provisions below very carefully. Your Blue Cross and Blue Shield identification card will give you the Medical Support Department's toll-free telephone number.

NOTE: The provisions of this Medical Support Program do not apply to the treatment of Mental Illness and Substance Abuse Rehabilitation Treatment. The provisions for the treatment of Mental Illness and Substance Abuse Rehabilitation Treatment are specified in the BLUE CROSS AND BLUE SHIELD MENTAL HEALTH UNIT section of this Certificate.

INPATIENT HOSPITAL SERVICES

- **Preadmission Review**

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

  Whenever a nonemergency or nonmaternity Inpatient Hospital admission is recommended by your Physician, you must, in order to receive maximum Out-of-Network benefits under this Certificate, call and comply with the recommendations of the Medical Support Department. This call must be made at least onethree business days prior to the scheduling of the Hospital admission and the performance of any preadmission tests for you to be eligible for maximum Out-of-Network benefits.

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

- **Emergency Admission Review**

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

In the event of an emergency admission, you or someone who calls on your behalf must, in order to receive maximum benefits under this Certificate, notify the Medical Support Department no later than onetwo business days or as soon as reasonably possible after the admission has occurred. If the call is made any later than the specified time period, you will not be eligible for maximum benefits.

- **Maternity Admission Review**

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

  When you are pregnant, you or someone who calls on your behalf must, in order to receive maximum Out-of-Network benefits under this Certificate, notify the Medical Support Department before the end of your first trimester of pregnancy. If the call is made any later than the specified time period, you will not be eligible for maximum Out-of-Network benefits.

  In the event of a maternity admission, you or someone who calls on your behalf must, in order to receive maximum Out-of-Network benefits under this Certificate, notify the Medical Support Department no later than onetwo business days after the admission has occurred in order to have the Inpatient Hospital admission reviewed. If the call is made any later than the specified time period, you will not be eligible for maximum Out-of-Network benefits.

- **Length of Stay Review**

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

  Upon completion of the preadmission review, the Medical Support Department will send you a letter confirming that you or your representative called the Medical Support Department regarding your hospitalization and stating the assigned length of stay. A letter assigning a length of stay to the admission will also be sent to the Physician and the Hospital. Upon completion of the emergency or maternity admission review and all subsequent length of stay extension reviews, a letter will be sent after your discharge. This letter will state the total length assigned for your entire admission, and will be sent to you, the attending Physician and the Hospital.

  Upon expiration of your assigned length of stay, the Medical Support Department will check with the Hospital to see if discharge has taken place. If discharge has not taken place, the Medical Support Department will obtain information on your clinical condition from the attending Physician or from the Hospital. An extension of the length of stay will be based solely on whether continued Inpatient care is Medically Necessary in the reasonable judgment of the Medical Support Department. Your Physician and the Hospital will be notified, by telephone, by the Medical Support Department of the assigned length of stay extension. A letter stating the total length assigned for your entire

admission will be sent to you, the attending Physician and the Hospital after your discharge. In the event that the extension is determined not to be warranted according to the criteria for Medically Necessary care, the length of stay will not be extended, and the case will be referred to a Blue Cross and Blue Shield Physician for review.

MEDICALLY NECESSARY DETERMINATION

The decision that Inpatient care, in the preadmission phase, and continued Inpatient care, in the length of stay extension phase, does not meet criteria for Medically Necessary care will be determined by a Blue Cross and Blue Shield Physician. Should the Blue Cross and Blue Shield Physician concur that the Inpatient care or continued Inpatient care is not Medically Necessary, written notification of the decision will be provided to you, your attending Physician, and the Hospital, and will specify the dates for which benefits will not be provided. For further details regarding Medically Necessary care and other exclusions from coverage under this Certificate, see the section entitled, ''EXCLUSIONS - WHAT IS NOT COVERED.''

The Medical Support Department does not determine your course of treatment or whether you receive particular health care services. The decision regarding the course of treatment and receipt of particular health care services is a matter entirely between you and your Physician. The Medical Support Department determination of Medically Necessary care is limited to merely whether a proposed admission or continued hospitalization meets the criteria for Medically Necessary care under this Certificate.

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

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

MEDICAL SUPPORT DEPARTMENT PROCEDURE

When you contact the Medical Support Department, you should be prepared to provide the following information:

1. your Blue Cross and Blue Shield group number and identification number;
2. the name of the attending and/or admitting Physician;
3. the name of the Hospital where the admission and/or service has been scheduled;

4. the scheduled admission and/or service date;
5. a preliminary diagnosis or reason for the admission and/or service; and
6. if applicable, the name of the procedure to be performed.

When you contact the Medical Support Department, the Medical Support Department:

1. will review the medical information provided and may follow up with the Provider;
2. may recommend that the service be performed on an Outpatient basis or that an alternative course of treatment be taken.

ADDITIONAL OPINION

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

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

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

APPEAL PROCEDURE

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

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

BlueChoiceMCNP Appeals Committee
Health Care Service Corporation
300 East Randolph
Chicago, Illinois 60601–5099

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

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

Within 30 days of receiving your request for review, Blue Cross and Blue Shield will send you its decision on the Claim. In unusual situations, an additional 15 days may be needed for the review and you will be notified of this during the first 30 day period.

YOUR DECISION AND FAILURE TO COMPLY

The final decision regarding your course of treatment is solely your responsibility and the Medical Support Department will not interfere with your relationship with any Hospital or Physician. However, Blue Cross and Blue Shield has established the Medical Support Department for the specific purpose of assisting you in determining the course of treatment which will maximize your benefits provided under this Certificate.

Should you fail to notify the Medical Support Department as required or fail to follow their recommendations, you will then be responsible for the first $ of the Hospital charges for an eligible Inpatient stay in addition to any deductibles, Copayments and/or Coinsurance applicable to this Certificate. This amount shall not be eligible for later consideration as an unreimbursed expense under any Benefit Section of this Certificate nor can it be applied to your out-of-pocket expense limit, if applicable to this Certificate. 26.01

MEDICARE ELIGIBLE MEMBERS

The Medical Support Department provisions of this Certificate do not apply to you if you are Medicare Eligible and have secondary coverage provided under this Certificate.

THE PARTICIPATING PROVIDER OPTION

[Your employer has chosen Blue Cross and Blue Shield's Participating Provider Option for the administration of your Hospital and Physician benefits and all other Covered Services. The Participating Provider Option is a program of health care benefits designed to provide you with economic incentives for using designated Providers of health care services.] PPO

[Your employer has chosen Blue Cross and Blue Shield's Community Participating Option for the administration of your Hospital and Physician benefits and all other Covered Services. The Community Participating Option program is Blue Cross and Blue Shield's Participating Provider Option program with an additional feature designed to provide you with economic incentives for using designated Providers of health care services in your local community.] CPO

[As a participant in the Participating Provider Option a directory of Participating Providers is available to you.][As a participant in the Community Participating Option, you will receive a listing of the Community Participating Provider(s) in your local community. In addition, a directory of Participating Providers will be available to you.] You can visit the Blue Cross and Blue Shield of Illinois Web site at *www.bcbsil.com* for a list of Participating Providers. While there may be changes in the directory from time to time, selection of [Community Providers and]Participating Providers by Blue Cross and Blue Shield will continue to be based upon the range of services, geographic location and cost-effectiveness of care. Notice of changes in the network will be provided to your Group Administrator annually, or as required, to allow you to make selection within the network. However, you are urged to check with your Provider before undergoing treatment to make certain of its participation status. Although you can go to the Hospital or Professional Provider of your choice, benefits under the [Participating Provider Option][Community Participating Option] will be greater when you use the services of a [Participating][Community] Provider[Hospital or Participating Professional Provider].]

Before reading the description of your benefits, you should understand the terms "Benefit Period" and "Deductible" as defined below.

YOUR BENEFIT PERIOD

Your benefit period is a period of one year which begins on [Month Day] of each year. When you first enroll under this coverage, your first benefit period begins on your Coverage Date, and ends on the first [Month Day] following that date. 22.20

[YOUR DEDUCTIBLE

[When you choose to use the services of a Community Provider, your deductible will be less than when you use another Provider. Each benefit period you must satisfy [a $[100–20,000] deductible][the deductible amount specified in the Benefit Highlights (an insert) of this Certificate] for Covered Services rendered by Community Provider(s). This deductible will be referred to as the program deductible. For Covered Services you receive from a Provider other than a Community Provider, the program deductible will be as stated below.] 22.01CPO 22.01CPOa 22.01CPOb

[Expenses incurred by you for Covered Services rendered by a Community Provider which are applied toward the Community Provider program deductible will also be applied toward the Participating Provider program deductible.] 22.01CPO

[Each benefit period you must satisfy[a $[100–20,000] deductible][the deductible amount specified in the Benefit Highlights (an insert) of this Certificate]. In other words, after you have Claims for Covered Services for more than the deductible amount in a benefit period, your benefits will begin. This deductible will be referred to as the program deductible.] 22.01a 22.01a1 22.01a2 22.01f

[Each benefit period you must satisfy [a $[100–20,000] deductible for Covered Services rendered by Participating Provider(s) and a separate $[200–60,000] deductible for Covered Services rendered by Non-Participating Provider(s) or Non-Plan Provider(s)][the deductible amount(s) specified in the Benefit Highlights (an insert) of this Certificate for Covered Services]. In other words, after you have Claims for Covered Services for more than the deductible amount in a benefit period, your benefits will begin. This deductible will be referred to as the program deductible.] 22.01b 22.01b1 22.01b2 22.01g

[Each benefit period you must satisfy[the deductible amount specified in the Benefit Highlights (an insert) of this Certificate][a $[200–60,000] deductible]for Covered Services received from Non-Participating Provider(s). In other words, after you have Claims for Covered Services received from Non-Participating Provider(s) for more than the specified dollar amount in a benefit period, your benefits will begin. This deductible will be referred to as the program deductible. This deductible does not apply to Covered Services received from Participating Providers.] 22.01c 22.01c1 22.01c2

[If you have Individual Coverage, each benefit period you must satisfy [a $[100–20,000] benefit program deductible][the deductible amount(s) specified in the Benefit Highlights (an insert) of this Certificate] before receiving benefits. After you have Claims for Covered Services in a benefit period which exceed this deductible amount, your benefits will begin.] 22.01d 22.01d1 22.01d2

[If you have Individual Coverage, each benefit period you must satisfy[a $[100–20,000] benefit program deductible for Covered Services rendered by Participating Provider(s) and a separate $[200–60,000] deductible for Covered Services rendered by Non-Participating Provider(s) or Non-Plan Provider(s)] [the deductible amount(s) specified in the Benefit Highlights (an insert) of this Certificate for Covered Services] before receiving benefits. After you have Claims for Covered Services in a benefit period which exceed the deductible amount, your benefits will begin.] 22.01e 22.01e1 22.01e2

[Expenses incurred by you for Covered Services rendered by a Participating Provider which are applied toward the Participating Provider program deductible will also be applied toward the Community Provider program deductible.] 22.01CPO

[Expenses incurred by you for Covered Services rendered by a Participating Provider which are applied toward the Participating Provider program deductible will also be applied toward the Non-Participating Provider program deductible.] 22.015

[Expenses incurred by you for Covered Services rendered by a Non-Participating Provider which are applied toward the Non-Participating Provider program deductible will also be applied toward the Participating Provider program deductible.] 22.014

[In addition to your program deductible, each time you are admitted to a Participating Hospital, you must satisfy [a $[100–5,000] deductible][the Inpatient deductible amount specified in the Benefit Highlights (an insert) of this Certificate].] 22.012 22.0121 22.0122

[Each time you are admitted to a Non-Participating Hospital or Non-Plan Hospital, you must satisfy [a $[100–5,000] deductible][the Inpatient deductible amount specified in the Benefit Highlights (an insert) of this Certificate]. This deductible is in addition to your program deductible.] 22.011 22.0111 22.0112

[If you have any expenses for Covered Services during the last three months of a benefit period which were or could have been applied to that benefit period's program deductible, these expenses may be applied toward the program deductible of the next benefit period.] 22.013

[If you have Family Coverage and [2,3] members of your family have each satisfied their program deductible, it will not be necessary for anyone else in your family to meet a program deductible in that benefit period. That is, for the remainder of that benefit period, no other family members are required to meet the program deductible before receiving benefits.] 22.02a

[If you have Family Coverage and your family has reached the program deductible [amount of $[100–20,000] for Covered Services rendered by Participating Provider(s) and a separate $[200–60,000] program deductible for Covered Services rendered by Non-Participating Provider(s) or Non-Plan Provider(s)][amount(s) specified in the Benefit Highlights (an insert) of this Certificate for Covered Services], it will not be necessary for anyone else in your family to meet the program deductible in that benefit period. That is, for the remainder of that benefit period only, no other family member(s) is required to meet the program deductible before receiving benefits. A family member may not apply more than the individual deductible amount toward the family deductible.] 22.02b 22.02b1 22.02b2

[If you have Family Coverage and your family has satisfied the family deductible amount [of $[100–20,000]][specified in the Benefit Highlights (an insert) of this Certificate], it will not be necessary for anyone else in your family to meet a benefit program deductible in that benefit period. That is, for the remainder of that benefit period, no other family members will be required to meet the benefit program deductible before receiving benefits. No one is eligible for benefits under Family Coverage until the entire family deductible amount has been satisfied.] 22.02c 22.02c1 22.02c2

[**The deductible amount may be adjusted based on the cost-of-living adjustment determined under the Internal Revenue Code and rounded to the nearest $50.**] 22.02c

[If you have Family Coverage and your family has reached the program deductible amount [of $[100–20,000]][specified in the Benefit Highlights (an insert) of this Certificate], it will not be necessary for anyone else in your family to meet a program deductible in that benefit period. That is, for the remainder of that benefit period, no other family members are required to meet a program deductible before receiving benefits. A family member may not apply more than the individual program deductible amount toward the family program deductible.] 22.02d 22.02d1 22.02d2

[If you have Family Coverage and your family has reached the program deductible amount [of $[200–60,000]][specified in the Benefit Highlights (an insert) of this Certificate] for Covered Services rendered by Non-Participating Provider(s) or Non-Plan

Provider(s), it will not be necessary for anyone else in your family to meet a program deductible in that benefit period. That is, for the remainder of that benefit period, no other family members are required to meet a program deductible before receiving benefits. A family member may not apply more than the individual program deductible amount toward the family program deductible. This deductible does not apply to Covered Services received from Participating Providers.] 22.02e 22.02e1 22.02e2

[If you have Family Coverage and your family has satisfied the family deductible [amount of $[100–20,000] for Covered Services rendered by Participating Provider(s) and a separate $[200–60,000] family deductible for Covered Services rendered by Non-Participating Provider(s) or Non-Plan Provider(s)][amount(s) specified in the Benefit Highlights (an insert) of this Certificate for Covered Services], it will not be necessary for anyone else in your family to meet a benefit program deductible in that benefit period. That is, for the remainder of that benefit period only, no other family member(s) will be required to meet the benefit program deductible before receiving benefits. No one is eligible for benefits under Family Coverage until the entire family deductible amount has been satisfied.] 22.02f 22.02f1 22.02f2

[**The deductible amount may be adjusted based on the cost-of-living adjustment determined under the Internal Revenue Code and rounded to the nearest $50.**] 22.02f

[If you have Family Coverage and your family has satisfied the family deductible amount [of $[100–20,000]][specified in the Benefit Highlights (an insert) of this Certificate], it will not be necessary for anyone else in your family to meet a benefit program deductible in that benefit period. That is, for the remainder of that benefit period, no other family members will be required to meet the benefit program deductible before receiving benefits.] 22.02g 22.02g1 22.02g2

[**The deductible amount may be adjusted based on the cost-of-living adjustment determined under the Internal Revenue Code and rounded to the nearest $50.**] 22.02g

[If you have Family Coverage and your family has satisfied the family deductible [amount of $[100–20,000] for Covered Services rendered by Participating Provider(s) and a separate $[200–60,000] family deductible for Covered Services rendered by Non-Participating Provider(s) or Non-Plan Provider(s)][amount(s) specified in the Benefit Highlights (an insert) of this Certificate for Covered Services], it will not be necessary for anyone else in your family to meet a benefit program deductible in that benefit period. That is, for the remainder of that benefit period only, no other family member(s) will be required to meet the benefit program deductible before receiving benefits.] 22.02h 22.02h1 22.02h2

[**The deductible amount may be adjusted based on the cost-of-living adjustment determined under the Internal Revenue Code and rounded to the nearest $50.**] 22.02h

[In any case, should two or more members of your family ever receive Covered Services as a result of injuries received in the same accident, only one program deductible will be applied against those Covered Services.] 22.021

[When your Group initially purchased this coverage, if you were a member of the Group at that time you are entitled to a special credit toward your [Participating Provider]program deductible for the first benefit period. This special credit applies to eligible expenses incurred for Covered Services within the prior contract's benefit period, if not completed. Such expenses can be applied toward the [Participating

Provider] program deductible for the first benefit period under this coverage. However, this is only true if your Group had "major medical" type coverage immediately prior to purchasing this coverage.]] 22.03

HOSPITAL BENEFIT SECTION

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

The benefits of this section are subject to all of the terms and conditions of this Certificate.[Your benefits are also subject to the Preexisting Condition waiting period.] 0.564
Please refer to the DEFINITIONS, ELIGIBILITY and EXCLUSIONS sections of this Certificate for additional information regarding any limitations and/or special conditions pertaining to your benefits.

In addition, the benefits described in this section will be provided only when you receive services on or after your Coverage Date and they are rendered upon the direction or under the direct care of your Physician. Such services must be Medically Necessary and regularly included in the Provider's charges.

[The level of benefits paid for Hospital Covered Services is generally greater when received in a Plan Hospital or other Plan facility.] 22.10

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

INPATIENT CARE

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

Inpatient Covered Services

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

Preadmission Testing

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

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

[Partial Hospitalization Treatment Program

[You must be admitted to this program within 72 hours of discharge from a covered Inpatient Hospital admission.]Benefits are available for this program only if it is a 22.62
Blue Cross and Blue Shield approved program. No benefits will be provided for services rendered in a Partial Hospitalization Treatment Program which has not been approved by Blue Cross and Blue Shield.]

[Benefits for Covered Services received in a Partial Hospitalization Treatment Program will be provided at the payment level specified for Inpatient treatment of Mental Illness and Inpatient Substance Abuse Rehabilitation Treatment in the SPECIAL CONDITIONS AND PAYMENT section of this Certificate.]] 22.68b

Coordinated Home Care Program

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

[Each time you are admitted to a Coordinated Home Care Program, you are entitled to benefits for [5–365] visits.] 22.60a

[You are entitled to benefits for [5–365] visits in a Coordinated Home Care Program per benefit period.] 22.60b

[Your benefits for Coordinated Home Care are combined with your benefits for [Skilled Nursing Facility Care] [and][Private Duty Nursing Service].][The maximum amount of benefits that will be provided for Coordinated Home Care[and][, Skilled Nursing Facility Care][and Private Duty Nursing Service] is a combined maximum of $[500–100,000] per benefit period.] 22.60c 22.60c1 22.60c2

BENEFIT PAYMENT FOR INPATIENT HOSPITAL COVERED SERVICES

[**Community Provider**

When you receive Inpatient Hospital Covered Services from a Community Provider, benefits will be provided at [[50–100]% of the Eligible Charge][the Community Provider Inpatient Hospital payment level specified in the Benefit Highlights (an insert) of this Certificate][after you have met your program deductible]. For Inpatient Hospital Covered Services you receive at a Hospital other than a Community Provider, benefit payment will be as described below.] 22.01CPO 22.11CPO 22.11CPOa 22.11CPOb

[**Participating Provider**

[When you receive Inpatient Covered Services from a Participating Provider or in a Plan Program of a Participating Provider, benefits will be provided at [50–100]% of the Eligible Charge[after you have met your program deductible][and your Inpatient Hospital admission deductible], unless otherwise specified in this Certificate. If you are in a private room, benefits will be limited by the Hospital's rate for its most common type of room with two or more beds.[Your program deductible will not apply to Inpatient Covered Services received from a Participating Provider.]] 22.11a1 22.012 22.11a2 22.11a

[When you receive Inpatient Covered Services from a Participating Provider or in a Plan Program of a Participating Provider, benefits will be provided at the Participating Provider Inpatient Hospital payment level specified in the Benefit Highlights (an insert) of this Certificate[after you have met your program deductible][and your Inpatient Hospital admission deductible], unless otherwise specified in this Certificate. If you are in a private room, benefits will be limited by the Hospital's rate for its most common type of room with two or more beds.][Your program deductible will not apply to Inpatient Covered Services received from a Participating Provider.]]] 22.012 22.11b

[Benefits for preadmission testing by a Participating Provider will be provided at [50–100]% of the Eligible Charge[after you have met your program deductible].[Benefits for preadmission testing will not be subject to the program deductible.]] 22.11c 22.11c1 22.11c2

[Benefits for services under a Coordinated Home Care Program of a Participating Provider will be provided at [50–100]% of the Eligible Charge[after you have met your program deductible].[Benefits for services under a Coordinated Home Care Program will not be subject to the program deductible.]] 22.11d 22.11d1 22.11d2

[Non-Participating Provider

When you receive Inpatient Covered Services from a Non-Participating Provider or in a Plan Program of a Non-Participating Provider, benefits will be provided at [50–100]% of the Eligible Charge, after you have met your program deductible[and your Inpatient Hospital admission deductible], unless otherwise specified in this Certificate. If you are in a private room, benefits will be limited by the Hospital's rate for its most common type of room with two or more beds.] 22.011 22.12a

[When you receive Inpatient Covered Services from a Non-Participating Provider or in a Plan Program of a Non-Participating Provider, benefits will be provided at the Non-Participating Provider Inpatient Hospital payment level specified in the Benefit Highlights (an insert) of this Certificate after you have met your program deductible[and your Inpatient Hospital admission deductible], unless otherwise specified in this Certificate. If you are in a private room, benefits will be limited by the Hospital's rate for its most common type of room with two or more beds.] 22.011 22.12b

[Benefits for preadmission testing by a Non-Participating Provider will be provided at [50–100]% of the Eligible Charge[after you have met your program deductible].[Benefits for preadmission testing will not be subject to the program deductible.]] 22.12c 22.12c1 22.12c2

[Benefits for services under a Coordinated Home Care Program of a Non-Participating Provider will be provided at [50–100]% of the Eligible Charge[after you have met your program deductible].[Benefits for services under a Coordinated Home Care Program will not be subject to the program deductible.]] 22.11d 22.11d1 22.11d2

[Non-Plan Provider

[When you receive Inpatient Covered Services from a Non-Plan Provider, benefits will be provided at 50% of the Eligible Charge after you have met your program deductible[and your Inpatient Hospital admission deductible]. 22.011

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

Benefits for an Inpatient Hospital admission to a Non-Plan or Non-Participating Hospital resulting from Emergency Accident Care or Emergency Medical Care will be provided at the Non-Participating Hospital payment level or the Non-Plan Hospital payment level (depending on the type of Provider) for that portion of your Inpatient

Hospital stay during which your condition is reasonably determined by Blue Cross and Blue Shield as not being serious and therefore permitting your safe transfer to a Participating Hospital or other Participating Provider.

In order for you to continue to receive benefits at the Participating Provider payment level following an emergency admission to a Non-Plan or Non-Participating Hospital, you must transfer to a Participating Provider as soon as your condition is no longer serious.] 22.13a

[When you receive Inpatient Covered Services from a Non-Plan Provider, benefits will be provided at the same benefit payment level which would have been paid had such services been received from a Non-Participating Provider.]] 22.13b

OUTPATIENT HOSPITAL CARE

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

Outpatient Hospital Covered Services

1. Surgery and any related Diagnostic Service received on the same day as the Surgery[
2. Autologous Chondrocyte Implantation (ACI) Surgery] NG
3. Radiation Therapy Treatments
4. Chemotherapy
5. Electroconvulsive Therapy
6. Renal Dialysis Treatments—if received in a Hospital, a Dialysis Facility or in your home under the supervision of a Hospital or Dialysis Facility
7. Diagnostic Service—when you are an Outpatient and these services are related to Surgery or Medical Care[
8. Urgent Care] 22.192
9. Emergency Accident Care—treatment must occur within 72 hours of the accident or as soon as reasonably possible.
10. Emergency Medical Care
11. Mammograms[—Benefits for routine mammograms will be provided at the benefit payment level described in the Wellness Care provision of this Certificate. Benefits for mammograms, other than routine, will be provided at the same payment level as Outpatient Diagnostic Service.] 22.56
12. Pap Smear Test—Benefits will be provided for an annual routine cervical smear or Pap smear test for females[at the benefit payment level described in the Wellness Care provision of this Certificate]. 22.56
13. Prostate Test and Digital Rectal Examination—Benefits will be provided for an annual routine prostate-specific antigen test and digital rectal examination for males[at the benefit payment level described in the Wellness Care provision of this Certificate]. 22.56

14. Ovarian Cancer Screening—Benefits will be provided for annual ovarian cancer screening for females using CA-125 serum tumor marker testing, transvaginal ultrasound, and pelvic examination.[Benefits will be provided at the benefit payment level described in the Wellness Care provision of this Certificate.] 22.56

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

    [Benefits for colorectal cancer screening will be provided at the benefit payment level described in the Wellness Care provision of this Certificate. Benefits for surgical procedures, such as colonoscopy and sigmoidoscopy, are not provided at the Wellness Care payment level. Such procedures will be provided at the benefit payment level for Surgery described in this Certificate.] 22.56

    [Benefits for colorectal cancer screening, including routine colonoscopy and sigmoidoscopy, will be provided at the benefit payment level described in the Wellness Care provision of this Certificate.] **New 9/09**

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

BENEFIT PAYMENT FOR OUTPATIENT HOSPITAL COVERED SERVICES

[**Community Provider**

When you receive Outpatient Hospital Covered Services from a Community Provider, benefits will be provided at [[50–100]% of the Eligible Charge][the Community Provider Outpatient Hospital payment level specified in the Benefit Highlights (an insert) of this Certificate][after you have met your program deductible]. 22.14CPO 22.14CPOa 22.14CPOb

[**Your benefits for Outpatient Diagnostic Service and mammograms will not be subject to the program deductible.**] 22.01CPO

For Outpatient Hospital Covered Services you receive at a Hospital other than a Community Provider, benefit payment will be as described below.] 22.14CPO

[**Participating Provider**

[Benefits will be provided at [50–100]% of the Eligible Charge [after you have met your program deductible]when you receive Outpatient Hospital Covered Services from a Participating Provider, unless otherwise specified in this Certificate.][Your program deductible will not apply.] 22.14a 22.14a1 22.14a2

[When you receive Outpatient Hospital Covered Services from a Participating Provider, benefits will be provided at the Participating Provider Outpatient Hospital payment level specified in the Benefit Highlights (an insert) of this Certificate[after

you have met your program deductible], unless otherwise specified in this Certificate.][Your program deductible will not apply.] 22.14b 22.14b1 22.14b2

[Benefits for Outpatient Surgery will be provided at [50–100]% of the Hospital's Eligible Charge from a Participating Provider[after you have met your program deductible]]. 22.16 22.16a1

[Benefits for Outpatient Surgery will not be subject to the program deductible.] 22.16b1

[Benefits for Outpatient Diagnostic Service and mammograms will be provided at [50–100]% of the Hospital's Eligible Charge from a Participating Provider [after you have met your program deductible].] 22.19 22.19a1

[Benefits for Outpatient Diagnostic Service and mammograms will not be subject to the program deductible.] 22.19b1

[Benefits for routine diagnostic tests will be provided at [50–100]% of the Hospital's Eligible Charge from a Participating Provider and will not be subject to the program deductible.] 22.191

[Benefits for urgent care from a Participating Provider will be provided at [50–100]% of the Hospital's Eligible Charge[after you have met your program deductible]]. 22.192a 22.192a1

[Benefits for urgent care from a Participating Provider will be provided at [50–100]% of the Hospital's Eligible Charge, subject to a Copayment of $[5–300] per visit]. 22.192b

[Benefits for urgent care will not be subject to the program deductible.]] 22.192c

[**Non-Participating Provider**

[When you receive Outpatient Hospital Covered Services from a Non-Participating Provider, benefits will be provided at [50–100]% of the Eligible Charge[after you have met your program deductible], unless otherwise specified in this Certificate.][Your program deductible will not apply.] 22.15a 22.15a1 22.15a2

[When you receive Outpatient Hospital Covered Services from a Non-Participating Provider, benefits will be provided at the Non-Participating Provider Outpatient Hospital payment level specified in the Benefit Highlights (an insert) of this Certificate[after you have met your program deductible], unless otherwise specified in this Certificate.][Your program deductible will not apply.] 22.15b 22.15a1 22.15a2

[Benefits for Outpatient Surgery will be provided at [50–100]% of the Hospital's Eligible Charge from a Non-Participating Provider[after you have met your program deductible].] 22.16 22.16a2

[Benefits for Outpatient Surgery will not be subject to the program deductible.] 22.16b2

[Benefits for Outpatient Diagnostic Service and mammograms will be provided at [50–100]% of the Hospital's Eligible Charge from a Non-Participating Provider [after you have met your program deductible].] 22.19 22.19a2

[Benefits for Outpatient Diagnostic Service and mammograms will not be subject to the program deductible.] 22.19b2

[Benefits for urgent care from a Non-Participating Provider will be provided at [50–100]% of the Hospital's Eligible Charge[after you have met your program deductible]]. 22.193a 22.193a1

[Benefits for urgent care from a Non-Participating Provider will be provided at [50–100]% of the Hospital's Eligible Charge, subject to a Copayment of $[5–300] per visit]. 22.193b

[Benefits for urgent care will not be subject to the program deductible.]] 22.193c

[**Non-Plan Provider**

[When you receive Outpatient Hospital Covered Services from a Non-Plan Provider, benefits will be provided at 50% of the Eligible Charge after you have met your program deductible. Covered Services received for Emergency Accident Care and Emergency Medical Care from a Non-Plan Provider will be paid at the same payment level which would have been paid had such services been received from a Participating Provider.] 22.141a

[When you receive Outpatient Hospital Covered Services from a Non-Plan Provider, benefits will be provided at the same payment level which would have been paid had such services been received from a Non-Participating Provider.]] 22.141b

[**Emergency Care**

[Benefits for Emergency Accident Care will be provided at [50–100]% of the Eligible Charge when you receive Covered Services from either a [Community,]Participating, Non-Participating or Non-Plan Provider. 22.17a

[Benefits for Emergency Accident Care will be subject to the [Participating Provider]program deductible.] 22.171a1 22.171a11

[Benefits for Emergency Accident Care will not be subject to the program deductible.]] 22.171a2

[Benefits for Emergency Medical Care will be provided at [50–100]% of the Eligible Charge when you receive Covered Services from either a [Community,]Participating, Non-Participating or Non-Plan Provider. 22.17b

[Benefits for Emergency Medical Care will be subject to the [Participating Provider]program deductible.] 22.171b1 22.17b11

[Benefits for Emergency Medical Care will not be subject to the program deductible.]] 22.171b2

[Benefits for Emergency Accident Care or Emergency Medical Care will be provided at the Emergency Accident Care or Emergency Medical Care payment levels specified in the Benefit Highlights (an insert) of this Certificate[after you have met your [Participating Provider]program deductible].][Your program deductible will not apply.] 22.174a 22.174a1 22.174 22.174b

[Each time you receive Covered Services in an emergency room, you will be responsible for a Copayment of $[5–300].][If you are admitted to the Hospital as an Inpatient immediately following emergency treatment, the emergency room Copayment will be waived.] 22.172 22.1721

[Each time you receive Covered Services in an emergency room, you will be responsible for the emergency room Copayment specified in the Benefit Highlights (an insert) of this Certificate.][If you are admitted to the Hospital as an Inpatient immedi- 22.173 22.1731

ately following emergency treatment, the emergency room Copayment will be waived.]

[However, Emergency Medical Care Covered Services for the examination and testing of a victim of criminal sexual assault or abuse to determine whether sexual contact occurred, and to establish the presence or absence of sexually transmitted disease or infection, will be paid at 100% of the Eligible Charge whether or not you have met your program deductible.][The emergency room Copayment will not apply.] 22.18a 22.18a1

[However, Covered Services received for Emergency Accident Care and Emergency Medical Care resulting from criminal sexual assault or abuse will be paid at 100% of the Eligible Charge whether or not you have met your program deductible.][The emergency room Copayment will not apply.]] 22.18b 22.18b1

[Outpatient Surgery,][Outpatient Diagnostic Service and Mammograms]

[Outpatient Surgery,][Outpatient Diagnostic Service and mammograms are not subject to your program deductible and benefits will be provided at the payment levels specified for [Outpatient Surgery and]Outpatient Diagnostic Service in the Benefit Highlights (an insert) of this Certificate.]

[Benefits for routine diagnostic tests will be provided at [50–100]% of the Hospital's Eligible Charge from a Participating Provider and will not be subject to the program deductible.] 22.16c1

[When you receive [Outpatient Surgery,]Outpatient Diagnostic Service and mammograms from a Non-Plan Provider, benefits will be provided at 50% of the Eligible Charge.] 22.16c

WHEN SERVICES ARE NOT AVAILABLE FROM A [COMMUNITY PROVIDER OR] PARTICIPATING PROVIDER (HOSPITAL)

If you must receive Hospital Covered Services which Blue Cross and Blue Shield has reasonably determined are unavailable from a [Community Provider or] Participating Provider, benefits for the Covered Services you receive from a Non-Participating Provider will be provided at the payment level described for a Participating Provider.

PHYSICIAN BENEFIT SECTION

This section of your Certificate tells you what services are covered and how much will be paid when you receive care from a Physician or other specified Professional Provider.

The benefits of this section are subject to all of the terms and conditions of this Certificate.[Your benefits are also subject to the Preexisting Condition waiting period.] 0.564
Please refer to the DEFINITIONS, ELIGIBILITY and EXCLUSIONS sections of this Certificate for additional information regarding any limitations and/or special conditions pertaining to your benefits.

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

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

COVERED SERVICES

Surgery

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

1. [surgical removal of complete bony impacted teeth; 22.76
2.]excision of tumors or cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth;
1.]excision of tumors or cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth;
2. surgical procedures to correct accidental injuries of the jaws, cheeks, lips, tongue, roof and floor of the mouth;
3. excision of exostoses of the jaws and hard palate (provided that this procedure is not done in preparation for dentures or other prostheses); treatment of fractures of facial bone; external incision and drainage of cellulitis; incision of accessory sinuses, salivary glands or ducts; reduction of dislocation of, or excision of, the temporomandibular joints.

The following services are also part of your surgical benefits:

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

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

2. Assist at Surgery—when performed by a Physician, Dentist or Podiatrist who assists the operating surgeon in performing covered Surgery in a Hospital or Ambulatory Surgical Facility. In addition, benefits will be provided for assist at Surgery when performed by [a Registered Surgical Assistant or]an Advanced Practice Nurse. Benefits will also be provided for assist at Surgery performed by a Physician Assistant under the direct supervision of a Physician, Dentist or Podiatrist.[
3. Sterilization Procedures[(even if they are elective)]][22.73
4. Autologous Chondrocyte Implantation (ACI) Surgery] NG

[**Additional Surgical Opinion**

Your coverage includes benefits for an additional surgical opinion following a recommendation for elective Surgery. Your benefits will be limited to one consultation and related Diagnostic Service by a Physician[. Benefits for an additional surgical opinion consultation and related Diagnostic Service will be provided at 100% of the Claim Charge][after you have met your program deductible].][Your program deductible will not apply to this benefit.] If you request, benefits will be provided for an additional consultation when the need for Surgery, in your opinion, is not resolved by the first arranged consultation.] 22.29 22.29a 22.29b

Medical Care

Benefits are available for Medical Care visits when:

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

[No benefits are available under this Benefit Section for the treatment of Mental Illness for those illnesses not classified as Serious Mental Illness or Outpatient Substance Abuse Rehabilitation Treatment. In addition, the treatment of Mental Illness and Substance Abuse Rehabilitation Treatment are subject to the maximums specified in the SPECIAL CONDITIONS AND PAYMENTS section of this Certificate.] 22.68a

[Your benefits for the Inpatient and Outpatient treatment of Mental Illness and Substance Abuse Rehabilitation Treatment will be provided as described in the SPECIAL CONDITIONS AND PAYMENTS section of this Certificate. However, benefits for the Inpatient treatment of Substance Abuse (i.e. detoxification and/or treatment of medical complications of Substance Abuse) will be provided as specified in the Benefit Payment for Physician Services provision of this Benefit Section.] 22.68b

Consultations

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

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 for such health care professionals will be provided at the Benefit Payment for Other Covered Services described in the OTHER COVERED SERVICES section of this Certificate. Benefits for Physicians will be provided at the Benefit Payment for Physician Services described later in this benefit section.

Benefits are also available for regular foot care examinations by a Physician or Podiatrist.

Well Child Care

Benefits will be provided for Covered Services provided by a Physician to children under age [one–21], even though they are not ill. Benefits will be limited to the following services:

1. immunizations[for children under age [one–21];] 22.552
2. physical examinations;
3. routine diagnostic tests. 22.55

[Benefits for well child care will be limited to a maximum of $[100–5,000] per benefit period [when you receive Covered Services from a Non-Participating Provider]. Benefits for the human papillomavirus vaccine are not subject to the well child care benefit maximum]. 22.551 22.551a

[**Nutritional Counseling**—Benefits will be provided for nutritional counseling[, limited to a maximum of [$[100–5,000]][[one–18] visits] per benefit period].] NG

Allergy Injections and Allergy Testing

Chemotherapy

Occupational Therapy

Benefits will be provided for Occupational Therapy when these services are rendered by a registered Occupational Therapist under the supervision of a Physician. This therapy must be furnished under a written plan established by a Physician and regularly reviewed by the therapist and Physician. The plan must be established before treatment is begun and must relate to the type, amount, frequency and duration of therapy and indicate the diagnosis and anticipated goals.[Benefits for Outpatient 22.630b

Occupational Therapy will be limited to a maximum of [$[100–20,000]][[5–365] visits] per benefit period.][Your benefits for Occupational Therapy, Physical Therapy and Speech Therapy are limited to a combined maximum of [[5–365] visits][$[1,000–60,000]] per benefit period.]

New 9/09

Physical Therapy

Benefits will be provided for Physical Therapy when rendered by a registered professional Physical Therapist under the supervision of a Physician. The therapy must be furnished under a written plan established by a Physician and regularly reviewed by the therapist and the Physician. The plan must be established before treatment is begun and must relate to the type, amount, frequency and duration of therapy and indicate the diagnosis and anticipated goals. Benefits will also be provided for preventive or Maintenance Physical Therapy when prescribed for persons affected by multiple sclerosis[, subject to the Outpatient Physical Therapy benefit maximum].[Benefits for Outpatient Physical Therapy will be limited to a maximum of [$[100–20,000]][[5–365] visits] per benefit period.][Your benefits for Occupational Therapy, Physical Therapy and Speech Therapy are limited to a combined maximum of [[5–365] visits][$[1,000–60,000]] per benefit period.]

New 9/09
22.63 22.63a 22.63b 22.630a

Radiation Therapy Treatments

Electroconvulsive Therapy

Speech Therapy

Benefits will be provided for Speech Therapy when these services are rendered by a licensed Speech Therapist or Speech Therapist certified by the American Speech and Hearing Association. Inpatient Speech Therapy benefits will be provided only if Speech Therapy is not the only reason for admission.[Benefits for Outpatient Speech Therapy will be limited to a maximum of [$[100–20,000]][[5–365] visits] per benefit period.][Your benefits for Occupational Therapy, Physical Therapy and Speech Therapy are limited to a combined maximum of [[5–365] visits][$[1,000–60,000]] per benefit period. However, benefits will be provided for an additional 20[20–365] visits for Speech Therapy for treatment of pervasive developmental disorders.][However, benefits will be provided for an additional [20–365] visits for Speech Therapy for treatment of pervasive developmental disorders.]

New 9/09

22.67 22.67a 22.67b 22.67a1

Clinical Breast Examinations—Benefits will be provided for clinical breast examinations when performed by a Physician, Advanced Practice Nurse or a Physician Assistant working under the direct supervision of a Physician.[Benefits for clinical breast examination will be provided at the benefit payment level described in the Wellness Care provision of this Certificate.]

22.56

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

Mammograms[—Benefits for routine mammograms will be provided at the benefit payment level described in the Wellness Care provision of this Certificate. Benefits for mammograms, other than routine, will be provided at the same payment level as Outpatient Diagnostic Service.]

22.56

Pap Smear Test—Benefits will be provided for an annual routine cervical smear or Pap smear test for females[at the benefit payment level described in the Wellness Care provision of this Certificate]. 22.56

Human Papillomavirus Vaccine—Benefits will be provided for a human papillomavirus (HPV) vaccine approved by the federal Food and Drug Administration.[Benefits will be provided at the benefit payment level for immunizations described in the Well Child Care provision of this Certificate for children under age [one–21].][Benefits will be provided at the benefit payment level for immunizations described in the Wellness Care provision of this Certificate[for persons age [one–21] and over].][Benefits will be provided at the benefit payment level for immunizations described in either the Wellness Care provision or the Well Child Care provision of this Certificate, whichever applies to you.] If you purchase the vaccine at a Pharmacy, benefits will be provided at the Benefit Payment for Other Covered Services described in the OTHER COVERED SERVICES section of this Certificate.

22.HPVa

22.HPVb

22.HPVc

Prostate Test and Digital Rectal Examination—Benefits will be provided for an annual routine prostate-specific antigen test and digital rectal examination for males [at the benefit payment level described in the Wellness Care provision of this Certificate]. 22.56

Ovarian Cancer Screening—Benefits will be provided for annual ovarian cancer screening for females using CA-125 serum tumor marker testing, transvaginal ultrasound, and pelvic examination.[Benefits for ovarian cancer screening will be provided at the benefit payment level described in the Wellness Care provision of this Certificate.] 22.56

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

[Benefits for colorectal cancer screening will be provided at the benefit payment level described in the Wellness Care provision of this Certificate. Benefits for surgical procedures, such as colonoscopy and sigmoidoscopy, are not provided at the Wellness Care payment level. Such procedures will be provided at the benefit payment level for Surgery described in this Certificate.] 22.56

[Benefits for colorectal cancer screening, including routine colonoscopy and sigmoidoscopy, will be provided at the benefit payment level described in the Wellness Care provision of this Certificate.] **New 9/09**

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

Emergency Accident Care—Treatment must occur within 72 hours of the accident or as soon as reasonably possible.

Emergency Medical Care

Chiropractic and Osteopathic Manipulation—Benefits will be provided for manipulation or adjustment of osseous or articular structures, commonly referred to as chiropractic and osteopathic manipulation, when performed by a person licensed to perform such procedures.[Your benefits for chiropractic and osteopathic manipulation will be limited to a maximum of [$[100–20,000]][[5–365] visits] per benefit period.]

22.65 22.65a 22.65b

[**Acupuncture**—Benefits will be provided for acupuncture[, limited to a maximum of [$[100–20,000]][[5–365] visits] per benefit period].]

NG

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

[**Leg, Back, Arm and Neck Braces**]

No longer used

[**Orthopedic Shoes and Shoe Inserts**—Benefits will be provided for orthopedic shoes or shoe inserts when prescribed by a Physician.[Your benefits will be limited to one pair of shoes or inserts per benefit period.]]

NG

[**Prosthetic Appliances**

Benefits will be provided for prosthetic devices, special appliances and surgical implants when:

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

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

22.54

22.282

[**Orthotic Devices**

Benefits will be provided for a supportive device for the body or a part of the body, head, neck or extremities, including but not limited to, leg, back, arm and neck braces. In addition, benefits will be provided for adjustments, repairs or replacement of the device because of a change in your physical condition, as Medically Necessary. However, benefits will not be provided for foot orthotics defined as any in-shoe device designed to support the structural components of the foot during weight-bearing activities.]

New

[**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.] 22.75

[No benefits will be provided for[abortions][or][surgical sterilization procedures].] 22.74

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

[**Routine Vision Examination**—Benefits will be provided for [one, 2] routine vision examination[(s)][, limited to a maximum of [$[30–600]][per benefit period].] 22.77 22.77a 22.77b

BENEFIT PAYMENT FOR PHYSICIAN SERVICES

The benefits provided by Blue Cross and Blue Shield and the expenses that are your responsibility for your Covered Services will depend on whether you receive services from a [Community,]Participating or Non-Participating Professional Provider.

[Your benefits for the treatment of Mental Illness for those illnesses not classified as Serious Mental Illness or Outpatient Substance Abuse Rehabilitation Treatment will be provided as described in the SPECIAL CONDITIONS AND PAYMENTS section of this Certificate. In addition, the treatment of Mental Illness and Substance Abuse Rehabilitation Treatment are subject to any benefit maximums specified in the SPECIAL CONDITIONS AND PAYMENTS section.] 22.68a

[Your benefits for the Inpatient and Outpatient treatment of Mental Illness and Substance Abuse Rehabilitation Treatment will be provided as described in the SPECIAL CONDITIONS AND PAYMENTS section of this Certificate.] 22.68b

[**Community Provider**

When you receive any of the Covered Services described in this Physician Benefit Section from a Community Provider, benefits will be provided at [[50–100]% of the Maximum Allowance][the Community Provider payment level for Surgical/Medical Covered Services specified in the Benefit Highlights (an insert) of this Certificate][after you have met your program deductible]. 22.21CPOa1 22.21CPOb1

[When you receive Covered Services in your Physician's office, benefits for office visits are subject to[a Copayment of $[5–100] per visit][the Physician's office Copayment amount specified in the Benefit Highlights (an insert) of this Certificate]. Benefits for office visits will then be provided at [[50–100]% of the Maximum Allowance][the Physician's office visit payment level specified in the Benefit Highlights (an insert) of this Certificate][after you have met your program deductible].[Your program deductible will not apply.]] 22.21CPOa2 22.21CPOb2 22.21CPOc2

[Your benefits for Outpatient Diagnostic Services and mammograms will not be subject to the program deductible.]

For Physician Covered Services you receive from a Provider other than a Community Provider, benefit payment will be as described below.] 22.21CPO

Participating Provider

[When you receive any of the Covered Services described in this Physician Benefit Section from a Participating Provider or from a Dentist, benefits will be provided at [50–100]% of the Maximum Allowance[after you have met your program deductible], unless otherwise specified in this Certificate. Although Dentists are not Participating Providers they will be treated as such for purposes of benefit payment made under this Certificate and may bill you for the difference between the Blue Cross and Blue Shield benefit payment and the Provider's charge to you.[Your program deductible will not apply.]] 22.21 22.21a 22.21b

[When you receive any of the Covered Services described in this Physician Benefit Section from a Participating Provider or from a Dentist, benefits will be provided at the Participating Provider payment level for Surgical/Medical Covered Services specified in the Benefit Highlights (an insert) of this Certificate[after you have met your program deductible], unless otherwise specified in this Certificate. Although Dentists are not Participating Providers they will be treated as such for purposes of benefit payment made under this Certificate and may bill you for the difference between the Blue Cross and Blue Shield benefit payment and the Provider's charge to you.[Your program deductible will not apply.]] 22.2b 22.2b1 22.2b2

[When you receive Covered Services in a Participating Provider's office[(other than a specialist's office)], benefits for office visits are subject to[a Copayment of $[5–100] per visit][the Physician's office Copayment amount specified in the Benefit Highlights (an insert) of this Certificate]. Benefits for office visits will then be provided at [[50–100]% of the Maximum Allowance][the Physician's office visit payment level specified in the Benefit Highlights (an insert) of this Certificate][after you have met your program deductible].[Your program deductible will not apply.]] 22.211bS 22.211b 22.211b1 22.211b2 22.211b3 22.211b4

[When you receive Covered Services in a Participating Provider specialist's office, benefits for office visits are subject to[a Copayment of $[5–100] per visit][the Participating Provider specialist's office Copayment amount specified in the Benefit Highlights (an insert) of this Certificate]. A specialist is a Professional Provider who is **not** a Physician in general practice, family practice, internal medicine, obstetrics, gynecology or pediatrics. Benefits for office visits will then be provided at [[50–100]% of the Maximum Allowance][the specialist's office visit payment level specified in the Benefit Highlights (an insert) of this Certificate][after you have met your program deductible].[Your program deductible will not apply.]] 22.211bSx

[When you receive Covered Services in a Participating Provider specialist's office, benefits for office visits are subject to[a Copayment of $[5–100] per visit][the Participating Provider specialist's office Copayment amount specified in the Benefit Highlights (an insert) of this Certificate]. A specialist is a Professional Provider who is **not** a Behavioral Health Practitioner or a Physician in general practice, family practice, internal medicine, [psychiatry,]obstetrics, gynecology or pediatrics. Benefits for office visits will then be provided at [[50–100]% of the Maximum Allowance][the

specialist's office visit payment level specified in the Benefit Highlights (an insert) of this Certificate][after you have met your program deductible].[Your program deductible will not apply.]]

Revised 22.211bS 22.211bS1 22.211bS2 22.211bS3 22.211bS4

[When you receive Covered Services in a Participating Provider specialist's office, benefits for office visits are subject to a Copayment of $[5–100] per visit. A specialist is a Professional Provider who is **not** a Physician in general practice, family practice, internal medicine, obstetrics, gynecology or pediatrics, a Certified Nurse-Midwife, a Certified Nurse Practitioner, or a Certified Clinical Nurse Specialist. Benefits for office visits will then be provided at [50–100]% of the Maximum Allowance[after you have met your program deductible].[Your program deductible will not apply.]]

22.211bSngx

[When you receive Covered Services in a Participating Provider specialist's office, benefits for office visits are subject to a Copayment of $[5–100] per visit. A specialist is a Professional Provider who is **not** a Behavioral Health Practitioner or a Physician in general practice, family practice, internal medicine, [psychiatry,]obstetrics, gynecology or pediatrics, a Certified Nurse-Midwife, a Certified Nurse Practitioner, or a Certified Clinical Nurse Specialist. Benefits for office visits will then be provided at [50–100]% of the Maximum Allowance[after you have met your program deductible].[Your program deductible will not apply.]]

Revised 22.211bSng 22.211bS1ng 22.211bS2ng

[When you receive Covered Services in a Participating Provider's office[(other than a specialist's office)], benefits for office visits will be provided at [[50–100]% of the Maximum Allowance][the Physician's office visit payment level specified in the Benefit Highlights (an insert) of this Certificate][after you have met your program deductible].[Your program deductible will not apply.]]

22.211cS

22.211c 22.211c1 22.211c2 22.211c3 22.211c4

[When you receive Covered Services in a Participating Provider specialist's office, benefits for office visits will be provided at [[50–100]% of the Maximum Allowance][the Physician's office visit payment level specified in the Benefit Highlights (an insert) of this Certificate][after you have met your program deductible].[Your program deductible will not apply.]] A specialist is a Professional Provider who is **not** a Physician in general practice, family practice, internal medicine, obstetrics, gynecology or pediatrics.

22.211cSx

[When you receive Covered Services in a Participating Provider specialist's office, benefits for office visits will be provided at [[50–100]% of the Maximum Allowance][the Physician's office visit payment level specified in the Benefit Highlights (an insert) of this Certificate][after you have met your program deductible].[Your program deductible will not apply.]] A specialist is a Professional Provider who is **not** a Behavioral Health Practitioner or a Physician in general practice, family practice, internal medicine, [psychiatry,]obstetrics, gynecology or pediatrics.

Revised 22.211cS 22.211cS1 22.211cS2 22.211cS3 22.211cS4

[When you receive Covered Services in a Participating Provider's office, benefits for office visits and all Covered Services billed with the office visit by the same Provider on the same day are subject to[a Copayment of $[5–100] per visit][the Physician's office Copayment amount specified in the Benefit Highlights (an insert) of this Certificate]. Benefits will then be provided at [[50–100]% of the Maximum Allowance][the Physician's office payment level specified in the Benefit Highlights (an insert) of this Certificate][after you have met your program deductible].[Your program deductible will not apply.]]

22.211d1 22.211d2

22.211d 22.211d3 22.211d4

[When you receive Covered Services [(except for those services specified below)]in a Participating Provider's office[(other than a specialist's office)], benefits for Covered Services[, including all related Covered Services received on the same day,] are subject to [a Copayment of $[5–100] per visit][the Physician's office Copayment amount specified in the Benefit Highlights (an insert) of this Certificate]. Benefits will then be provided at [[50–100]% of the Maximum Allowance][the Physician's office payment level specified in the Benefit Highlights (an insert) of this Certificate][after you have met your program deductible].[Your program deductible will not apply.]

22.211a2
22.211aS
22.211a5
22.211a 22.211a1
22.211a3 22.211a4 22.211a6

[When you receive Covered Services [(except for those services specified below)]in a Participating Provider specialist's office, benefits for Covered Services[, including all related Covered Services received on the same day,] are subject to [a Copayment of $[5–100] per visit][the Participating Provider specialist's office Copayment amount specified in the Benefit Highlights (an insert) of this Certificate]. A specialist is a Professional Provider who is **not** a Physician in general practice, family practice, internal medicine, obstetrics, gynecology or pediatrics. Benefits will then be provided at [[50–100]% of the Maximum Allowance][the specialist's office payment level specified in the Benefit Highlights (an insert) of this Certificate][after you have met your program deductible].[Your program deductible will not apply.]

22.211a2
22.211aS5
22.211aS1 22.211aS2
22.211aS 22.211aS3 22.211aS4

[When you receive Covered Services [(except for those services specified below)]in a Participating Provider specialist's office, benefits for Covered Services[, including all related Covered Services received on the same day,] are subject to [a Copayment of $[5–100] per visit][the Participating Provider specialist's office Copayment amount specified in the Benefit Highlights (an insert) of this Certificate]. A specialist is a Professional Provider who is **not** a Behavioral Health Practitioner or a Physician in general practice, family practice, internal medicine, obstetrics, [psychiatry,]gynecology or pediatrics. Benefits will then be provided at [[50–100]% of the Maximum Allowance][the specialist's office payment level specified in the Benefit Highlights (an insert) of this Certificate][after you have met your program deductible].[Your program deductible will not apply.]

22.211a2
22.211aS5
22.211aS1 22.211aS2
Revised 22.211aS 22.211aS3 22.211aS4

[The following Covered Services are not subject to the [Participating Provider][specialist]office visit Copayment, and benefits will be provided at the general medical/surgical payment level, unless otherwise specified in this Certificate:[22.211a2

- Surgery][22.211a2a
- Occupational Therapy][22.211a2b
- Physical Therapy][22.211a2c
- Speech Therapy][22.211a2d
- Diagnostic Services][22.211a2e
- MRI, CT Scan, [EKG, EEG, ECG,]pulmonary function studies, cardiac catheterization and swan ganz catheterization][22.211a2f 22.211a2f
- Chiropractic and osteopathic manipulation][22.211a2g
- [Allergy injections][and][allergy testing]] 22.211a2h

[When you receive Covered Services for well child care from a Participating Provider, benefits will be provided at [50–100]% of the Maximum Allowance[subject to the Physician office visit Copayment].] 22.2121

[When you receive Covered Services for well child care from a Participating Provider, benefits will be provided at [50–100]% of the Maximum Allowance, subject to a Copayment of $[5–100] per visit. 22.2122

[When you receive Covered Services for well child care from a Participating Provider, benefits will be provided at the well child care payment level specified in the Benefit Highlights (an insert) of this Certificate[, subject to the Physician office visit Copayment][, subject to the Copayment amount specified in the Benefit Highlights (an insert) of this Certificate]. 22.212G 22.212G1

[Benefits for well child care from a Participating Provider will be subject to the program deductible.] 22.212a

[Benefits for well child care from a Participating Provider will not be subject to the program deductible.] 22.212b

[When you receive Outpatient Occupational Therapy, Outpatient Physical Therapy, or Outpatient Speech Therapy from a Participating Provider, benefits will be provided at [50–100]% of the Maximum Allowance[, subject to a Copayment of $[5–100] per visit]. 22.214 22.2141

[Benefits for Outpatient Occupational Therapy, Outpatient Physical Therapy, or Outpatient Speech Therapy from a Participating Provider will be subject to your program deductible.] 22.214a

[Benefits for Outpatient Occupational Therapy, Outpatient Physical Therapy, or Outpatient Speech Therapy from a Participating Provider will not be subject to your program deductible.] 22.214b

[Benefits for chiropractic and osteopathic manipulation will be provided at [50–100]% of the Maximum Allowance[, subject to the Physician office visit Copayment,] when Covered Services are received from a Participating Provider.] 22.2131

[Benefits for chiropractic and osteopathic manipulation will be provided at [50–100]% of the Maximum Allowance, subject to a Copayment of $[5–100] per visit, when Covered Services are received from a Participating Provider.] 22.2132

[Benefits for chiropractic and osteopathic manipulation from a Participating Provider will be subject to the program deductible.] 22.213a

[Benefits for chiropractic and osteopathic manipulation from a Participating Provider will not be subject to the program deductible.] 22.213b

[Benefits for Outpatient Surgery will be provided at [50–100]% of the Maximum Allowance from a Participating Provider[after you have met your program deductible].] 22.26 22.26a

[Benefits for Outpatient Surgery will not be subject to the program deductible.] 22.26b

[Benefits for Outpatient Diagnostic Service and mammograms will be provided at [50–100]% of the Maximum Allowance from a Participating Provider[after you have met your program deductible].] 22.27 22.27a

[Benefits for Outpatient Diagnostic Service and mammograms will not be subject to the program deductible.] 22.27b

[Benefits for routine vision examinations by a Participating Provider will be provided at [50–100]% of the Maximum Allowance[after you have met your program deductible].][Your program deductible will not apply.] 22.215 22.215a 22.215b

Non-Participating Provider

[When you receive any of the Covered Services described in this Physician Benefit Section from a Non-Participating Provider, benefits will be provided at [50–100]% of the Maximum Allowance[after you have met your program deductible][, unless otherwise specified in this Certificate].[Your program deductible will not apply.]] 22.22a 22.22a3 22.22a4

[When you receive any of the Covered Services described in this Physician Benefit Section from a Non-Participating Provider, benefits will be provided at the Non-Participating Provider payment level for Surgical/Medical Covered Services specified in the Benefit Highlights (an insert) of this Certificate[after you have met your program deductible], unless otherwise specified in this Certificate.[Your program deductible will not apply.]] 22.2b 22.2b1 22.2b2

[When you receive Covered Services in a Non-Participating Provider's office[(other than a specialist's office)], benefits for office visits are subject to[a Copayment of $[5–100] per visit][the Physician's office Copayment amount specified in the Benefit Highlights (an insert) of this Certificate]. Benefits for office visits will then be provided at [[50–100]% of the Maximum Allowance][the Physician's office visit payment level specified in the Benefit Highlights (an insert) of this Certificate][after you have met your program deductible].[Your program deductible will not apply.]] 22.222bS 22.222b1 22.222b2 22.222b 22.222b3 22.222b4

[When you receive Covered Services in a Non-Participating Provider specialist's office, benefits for office visits are subject to[a Copayment of $[5–100] per visit][the Non-Participating Provider specialist's office Copayment amount specified in the Benefit Highlights (an insert) of this Certificate]. A specialist is a Professional Provider who is **not** a Physician in general practice, family practice, internal medicine, gynecology or pediatrics. Benefits for office visits will then be provided at [[50–100]% of the Maximum Allowance][the specialist's office visit payment level specified in the Benefit Highlights (an insert) of this Certificate][after you have met your program deductible].[Your program deductible will not apply.]] 22.222bS 22.222bS1 22.222bS2 22.222bS3 22.222bS4

[When you receive Covered Services in a Non-Participating Provider specialist's office, benefits for office visits are subject to[a Copayment of $[5–100] per visit][the Non-Participating Provider specialist's office Copayment amount specified in the Benefit Highlights (an insert) of this Certificate]. A specialist is a Professional Provider who is **not** a Behavioral Health Practitioner or a Physician in general practice, family practice, internal medicine, [psychiatry,]gynecology or pediatrics. Benefits for office visits will then be provided at [[50–100]% of the Maximum Allowance][the specialist's office visit payment level specified in the Benefit Highlights (an insert) of this Certificate][after you have met your program deductible].[Your program deductible will not apply.]] **Revised** 22.222bS 22.222bS1 22.222bS2 22.222bS3 22.222bS4

[When you receive Covered Services in a Non-Participating Provider's office[(other than a specialist's office)], benefits for office visits will be provided at [[50–100]% of the Maximum Allowance][the Physician's office visit payment level specified in the 22.222cS 22.222c1 22.222c2

Benefit Highlights (an insert) of this Certificate][after you have met your program deductible].[Your program deductible will not apply.]] 22.222c 22.222c3 22.222c4

[When you receive Covered Services in a Non-Participating Provider specialist's office, benefits for office visits will be provided at [[50–100]% of the Maximum Allowance][the specialist's office visit payment level specified in the Benefit Highlights (an insert) of this Certificate][after you have met your program deductible].[Your program deductible will not apply.]] A specialist is a Professional Provider who is **not** a Physician in general practice, family practice, internal medicine, obstetrics, gynecology or pediatrics. 22.222cS 22.222cS1 22.222cS2 22.222cS3 22.222cS4

[When you receive Covered Services in a Non-Participating Provider's office, benefits for office visits will be provided at [[50–100]% of the Maximum Allowance][the specialist's office visit payment level specified in the Benefit Highlights (an insert) of this Certificate][after you have met your program deductible].[Your program deductible will not apply.]] A specialist is a Professional Provider who is **not** a Behavioral Health Practitioner or a Physician in general practice, family practice, internal medicine, [psychiatry,]obstetrics, gynecology or pediatrics. **Revised** 22.222cS 22.222cS1 22.222cS2 22.222cS3 22.222cS4

[When you receive Covered Services in a Non-Participating Provider's office, benefits for office visits and all Covered Services billed with the office visit by the same Provider on the same day are subject to[a Copayment of $[5–100] per visit][the Physician's office Copayment amount specified in the Benefit Highlights (an insert) of this Certificate]. Benefits will then be provided at [[50–100]% of the Maximum Allowance][the Physician's office payment level specified in the Benefit Highlights (an insert) of this Certificate][after you have met your program deductible].[Your program deductible will not apply.]] 22.222d1 22.222d2 22.222d 22.222d3 22.222d4

[When you receive Covered Services[(except for those services specified below)] in a Non-Participating Provider's office[(other than a specialist's office)], benefits for Covered Services[, including all related Covered Services received on the same day,] are subject to [a Copayment of $[5–100] per visit][the Physician's office Copayment amount specified in the Benefit Highlights (an insert) of this Certificate]. Benefits will then be provided at [[50–100]% of the Maximum Allowance][the Physician's office payment level specified in the Benefit Highlights (an insert) of this Certificate][after you have met your program deductible].[Your program deductible will not apply.] 22.222a2 22.222a5 22.222a1 22.222a6 22.222a 22.222a3 22.222a4

[When you receive Covered Services [(except for those services specified below)]in a Non-Participating Provider specialist's office, benefits for Covered Services[, including all related Covered Services received on the same day,] are subject to [a Copayment of $[5–100] per visit][the Non-Participating Provider specialist's office Copayment amount specified in the Benefit Highlights (an insert) of this Certificate]. A specialist is a Professional Provider who is **not** a Physician in general practice, family practice, internal medicine, obstetrics, gynecology or pediatrics. Benefits will then be provided at [[50–100]% of the Maximum Allowance][the specialist's office payment level specified in the Benefit Highlights (an insert) of this Certificate][after you have met your program deductible].[Your program deductible will not apply.] 22.222aSx

[When you receive Covered Services [(except for those services specified below)]in a Non-Participating Provider specialist's office, benefits for Covered Services[, including all related Covered Services received on the same day,] are subject to [a 22.222a2 22.222aS5

Copayment of $[5–100] per visit][the Non-Participating Provider specialist's office Copayment amount specified in the Benefit Highlights (an insert) of this Certificate]. A specialist is a Professional Provider who is **not** a Behavioral Health Practitioner or a Physician in general practice, family practice, internal medicine, [psychiatry,]obstetrics, gynecology or pediatrics. Benefits will then be provided at [[50–100]% of the Maximum Allowance][the specialist's office payment level specified in the Benefit Highlights (an insert) of this Certificate][after you have met your program deductible].[Your program deductible will not apply.]

Revised 22.222aS1 22.222aS2

22.222aS 22.222aS3 22.222aS4

[The following Covered Services are not subject to the [Non-Participating Provider][specialist]office visit Copayment, and benefits will be provided at the general medical/surgical payment level, unless otherwise specified in this Certificate:[

22.222a2

- Surgery][22.222a2a
- Occupational Therapy][22.222a2b
- Physical Therapy][22.222a2c
- Speech Therapy][22.222a2d
- Diagnostic Services][22.222a2e
- MRI, CT Scan, [EKG, EEG, ECG,]pulmonary function studies, cardiac catheterization and swan ganz catheterization][22.222a2f 22.222af1
- Chiropractic and osteopathic manipulation][22.222a2g
- [Allergy injections][and][allergy testing]] 22.222a2h

[Benefits for well child care will be provided at [50–100]% of the Maximum Allowance[, after you have met your program deductible][and will not be subject to your program deductible].]

22.22a1 22.22a11 22.22a12

[Benefits for well child care will be provided at the well child care payment level for Non-Participating Providers specified in the Benefit Highlights (an insert) of this Certificate[, after you have met your program deductible][and will not be subject to your program deductible].]

22.22a1G 22.22a1G1 22.22a1G2

[When you receive Covered Services for well child care from a Non-Participating Provider, benefits will be provided at [50–100]% of the Maximum Allowance, subject to a Copayment of $[5–100] per visit.

22.22a13

[When you receive Covered Services for well child care from a Non-Participating Provider, benefits will be provided at the well child care payment level specified in the Benefit Highlights (an insert) of this Certificate[, subject to the Physician office visit Copayment][, subject to the Copayment amount specified in the Benefit Highlights (an insert) of this Certificate].

22.22a13G

[When you receive Outpatient Occupational Therapy, Outpatient Physical Therapy, or Outpatient Speech Therapy from a Non-Participating Provider, benefits will be provided at [50–100]% of the Maximum Allowance[, subject to a Copayment of $[5–100] per visit].

22.224 22.2241

[Benefits for Outpatient Occupational Therapy, Outpatient Physical Therapy, or Outpatient Speech Therapy from a Non-Participating Provider will be subject to your program deductible.]

22.224a

[Benefits for Outpatient Occupational Therapy, Outpatient Physical Therapy, or Outpatient Speech Therapy from a Non-Participating Provider will not be subject to your program deductible.] 22.224b

[Benefits for chiropractic and osteopathic manipulation will be provided at [50–100]% of the Maximum Allowance[, after you have met your program deductible][and will not be subject to your program deductible].] 22.22a2 22.22a22 22.22a23

[Benefits for chiropractic and osteopathic manipulation will be provided at [50–100]% of the Maximum Allowance, subject to a Copayment of $[5–100] per visit, when Covered Services are received from a Non-Participating Provider.] 22.22a24

[Benefits for Outpatient Surgery will be provided at [50–100]% of the Maximum Allowance from a Non-Participating Provider[after you have met your program deductible].] 22.26 22.26a2

[Benefits for Outpatient Surgery will not be subject to the program deductible.] 22.26b2

[Benefits for Outpatient Diagnostic Service and mammograms will be provided at [50–100]% of the Maximum Allowance from a Non-Participating Provider[after you have met your program deductible].] 22.27 22.27a2

[Benefits for Outpatient Diagnostic Service and mammograms will not be subject to the program deductible.] 22.27b2

[Benefits for routine vision examinations by a Non-Participating Provider will be provided at [50–100]% of the Maximum Allowance[after you have met your program deductible].][Your program deductible will not apply.] 22.225 22.225a 22.225b

Chiropractic and Osteopathic Manipulation 22.221

[Benefits for chiropractic and osteopathic manipulation will be provided at [50–100]% of the Maximum Allowance when rendered by either a Participating or Non-Participating Provider[after you have met your program deductible].] 22.221a

[Benefits for chiropractic and osteopathic manipulation will not be subject to the program deductible.] 22.221b

Emergency Care

[Benefits for Emergency Accident Care[other than in the Provider's office] will be provided at [50–100]% of the Maximum Allowance when rendered by either a [Community, Participating or Non-Participating Provider[after you have met your Participating Provider program deductible].[Your program deductible will not apply.]

[When you receive Covered Services for Emergency Accident Care in a Provider's office, benefits for office visits are subject to[a Copayment of $[5–100] per visit][the Physician's office Copayment amount specified in the Benefit Highlights (an insert) of this Certificate]. Benefits for office visits will be provided at [[50–100]% of the Maximum Allowance][the payment level specified in the Benefit Highlights (an insert) of this Certificate].] 22.761 22.761a 22.761b

[When you receive Emergency Accident Care in a Professional Provider's office, benefits for Emergency Accident Care Covered Services are subject to[a Copayment of $[5–100] per visit][the Emergency Accident Care office Copayment amount spe- 22.7611 22.7611a 22.7611a1 22.761lb

cified in the Benefit Highlights (an insert) of this Certificate] and will be provided at [[50–100]% of the Maximum Allowance][the payment level specified in the Benefit Highlights (an insert) of this Certificate][after you have met your Participating Provider program deductible].[Your program deductible will not apply.]]

[Benefits for Emergency Medical Care[other than in the Provider's office] will be provided at [50–100]% of the Maximum Allowance when rendered by either a [Community,]Participating or Non-Participating Provider[after you have met your Participating Provider program deductible].[Your program deductible will not apply.]

22.232 22.232a 22.232a1 22.232b

[When you receive Covered Services for Emergency Medical Care in a Provider's office, benefits for office visits are subject to[a Copayment of $[5–100] per visit][the Physician's office Copayment amount specified in the Benefit Highlights (an insert) of this Certificate]. Benefits for office visits will be provided at [50–100]% of the Maximum Allowance.]

22.771 22.771a 22.771b

[When you receive Emergency Medical Care in a Professional Provider's office, benefits for Emergency Medical Care Covered Services are subject to[a Copayment of $[5–100] per visit][the Emergency Medical Care office Copayment amount specified in the Benefit Highlights (an insert) of this Certificate] and will be provided at [[50–100]% of the Maximum Allowance][the payment level specified in the Benefit Highlights (an insert) of this Certificate][after you have met your [Participating Provider]program deductible].[Your program deductible will not apply.]]

22.7711 22.7711a 22.7711a1 22.771lb

[Benefits for Emergency Accident Care or Emergency Medical Care[other than in the Provider's office] will be provided at the Emergency Accident Care or Emergency Medical Care payment levels specified in the Benefit Highlights (an insert) of this Certificate[after you have met your [Participating Provider]program deductible].][Your program deductible will not apply.]

22.233 22.233a 22.233b

[However, Emergency Medical Care Covered Services for the examination and testing of a victim of criminal sexual assault or abuse to determine whether sexual contact occurred, and to establish the presence or absence of sexually transmitted disease or infection, will be paid at 100% of the Maximum Allowance whether or not you have met your program deductible.[The office Copayment will not apply.]]

22.25a 22.25a1

[However, Covered Services for Emergency Accident Care and Emergency Medical Care resulting from a criminal sexual assault or abuse will be paid at 100% of the Maximum Allowance whether or not you have met your program deductible.[The office Copayment will not apply.]]

22.25b 22.25b1

[**Community Providers and]Participating Providers are:**

- Physicians
- Podiatrists
- Psychologists
- Certified Clinical Nurse Specialists
- Certified Nurse-Midwives
- Certified Nurse Practitioners

- Certified Registered Nurse Anesthetists
- Chiropractors
- Clinical Laboratories
- Clinical Professional Counselors
- Clinical Social Workers
- Durable Medical Equipment Providers
- Home Infusion Therapy Providers
- Marriage and Family Therapists
- Occupational Therapists[
- Optometrists][
- Orthotic Providers]
- Physical Therapists[
- Prosthetic Providers][
- Registered Surgical Assistants][
- Retail Health Clinics]
- Speech Therapists

who have signed an Agreement with Blue Cross and Blue Shield to accept the Maximum Allowance as payment in full. Such [Community Providers and]Participating Providers have agreed not to bill you for Covered Services amounts in excess of the Maximum Allowance. Therefore, you will be responsible only for the difference between the Blue Cross and Blue Shield benefit payment and the Maximum Allowance for the particular Covered Service — that is, your program deductible, Copayment and Coinsurance amounts.

Non-Participating Providers are:

- Physicians
- Podiatrists
- Psychologists
- Dentists
- Certified Nurse-Midwives
- Certified Nurse Practitioners
- Certified Clinical Nurse Specialists
- Certified Registered Nurse Anesthetists
- Chiropractors
- Clinical Social Workers
- Clinical Professional Counselors

- Clinical Laboratories
- Durable Medical Equipment Providers
- Home Infusion Therapy Providers
- Marriage and Family Therapists
- Occupational Therapists[
- Optometrists][
- Orthotic Providers]
- Physical Therapists[
- Prosthetic Providers][
- Registered Surgical Assistants][
- Retail Health Clinics]
- Speech Therapists
- other Professional Providers

who have not signed an agreement with Blue Cross and Blue Shield to accept the Maximum Allowance as payment in full. Therefore, you are responsible to these Providers for the difference between the Blue Cross and Blue Shield benefit payment and such Provider's charge to you.

Should you wish to know the Maximum Allowance for a particular procedure or whether a particular Provider is a [Community Provider or]Participating Provider, contact your Group Administrator, your Professional Provider or Blue Cross and Blue Shield.

[Regarding the Schedule of Maximum Allowances, you should also understand the following:

If two or more surgical procedures are related or performed in the same operative area and are performed by the same or different Physician, Dentist or Podiatrist during the same operation, benefits will be provided only for the procedure which has the larger Maximum Allowance.

If two or more surgical procedures are related or are performed in the same operative area, and are performed on different dates by the same or a different Physician, Dentist or Podiatrist, benefits will be based upon the procedure which has the largest Maximum Allowance and 50% of the Maximum Allowance for the procedure which has the next largest allowance.

Procedures performed for conditions resulting from the same accident or injury are considered related.

If a surgical procedure is repeated during an Inpatient stay, the benefit payment will be based upon 50% of the Maximum Allowance for such repeat procedure and only one such repeat will be considered a Covered Service.] 22.24

OTHER COVERED SERVICES

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

- Blood and blood components.[
- Leg, back, arm and neck braces.] 22.35
- Private Duty Nursing Service—Benefits for Private Duty Nursing Service will be provided to you in your home only when the services are of such a nature that they cannot be provided by non-professional personnel and can only be provided by a licensed health care provider. No benefits will be provided when a nurse ordinarily resides in your home or is a member of your immediate family. Private Duty Nursing includes teaching and monitoring of complex care skills such as tracheotomy suctioning, medical equipment use and monitoring to home caregivers and is not intended to provide for long term supportive care. Benefits for Private Duty Nursing Service will not be provided due to the lack of willing or available non-professional personnel.[Your benefits for Private Duty Nursing Service are limited to a maximum of [$[500–100,000]][[5–365] days] per month.][Your benefits for Private Duty Nursing Service are limited to a maximum of [$[500–100,000]][[5–365] days] per benefit period.] 22.64a 22.641 22.642 22.64b 22.643 22.644

  [Your benefits for Private Duty Nursing are combined with your benefits for [Skilled Nursing Facility Care] and[Coordinated Home Care]. The maximum amount of benefits that will be provided for Private Duty Nursing and[Skilled Nursing Facility Care[Coordinated Home Care] is a combined maximum of $[500–100,000] per benefit period.] 22.64c
- Ambulance Transportation—Benefits will not be provided for long distance trips or for use of an ambulance because it is more convenient than other transportation.
- Dental accident care—Dental services rendered by a Dentist or Physician which are required as the result of an accidental injury.
- Oxygen and its administration
- Medical and surgical dressings, supplies, casts and splints[
- Prosthetic appliances—Benefits will be provided for prosthetic devices, special appliances and surgical implants when:

  a. they are required to replace all or part of an organ or tissue of the human body, or

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

  Benefits will also include adjustments, repair and replacements of covered prosthetic devices, special appliances and surgical implants when required because of wear or change in a patient's condition (excluding dental appliances [other than intra-oral devices used in connection with the treatment of Temporomandibular Joint Dysfunction and Related Disorders, subject to specific limitations applicable to Temporomandibular Joint Dysfunction and Related Disorders, 22.54

]and replacement of cataract lenses when a prescription change is not required).][22.35

- Optometric services—Benefits will be provided for services which may be legally rendered by an Optometrist, provided that benefits would have been provided had such services been rendered by a Physician.][22.34
- Outpatient drugs and medicines—All drugs and medicines, except drugs used for cosmetic purposes (including, but not limited to, Retin-A/Tretinoin and Minoxidil/Rogaine), which require by law a written prescription and which are dispensed by a Pharmacy or Physician. In addition, your coverage includes benefits for insulin and insulin syringes even though a prescription may not be required by law.][22.31
- Naprapathic Service—Benefits will be provided for Naprapathic Services when rendered by a Naprapath.[Benefits for Naprapathic Services will be limited to a maximum of $[200–60,000] per benefit period.]][22.70
- Wigs—Benefits will be provided for wigs (also known as cranial prostheses) when your hair loss is due to Chemotherapy, radiation therapy or alopecia.[22.36
  Benefits for wigs will be limited to $[100–5,000] per benefit period.][Benefits 22.36a
  for wigs will be limited to a lifetime maximum of] $[100–5,000].] 22.36b
- Orthopedic shoes and shoe inserts—Benefits will be provided for orthopedic shoes or shoe inserts when prescribed by a Physician.[Your benefits will be limited to one pair of shoes or inserts per benefit period.]] NG

BENEFIT PAYMENT FOR OTHER COVERED SERVICES

[**After you have met your program deductible, benefits will be provided at [50–100]% of the Eligible Charge or [50–100]% of the Maximum Allowance for any of the Covered Services described in this section. [However, benefits for Outpatient drugs and medicines will be provided at [50–100]% of the Eligible Charge, after you have met your program deductible.**] 22.33a 22.PD

[**Benefits will be provided at the Other Covered Services payment level specified in the Benefit Highlights (an insert) of this Certificate after you have met your program deductible for any of the Covered Services described in this section.[However, benefits for Outpatient drugs and medicines will be provided at [50–100]% of the Eligible Charge, after you have met your program deductible.**]] 22.33b 22.PD

[When you receive Other Covered Services from a [Community,]Participating or Non-Participating Provider, benefits for Other Covered Services will be provided at the payment levels previously described in this Certificate for Hospital and Physician Covered Services.]

[The expenses that are your responsibility for your Other Covered Services will depend on whether you receive services from a [Community,]Participating or Non-Participating Professional Provider.]

[[**Community Providers and]Participating Providers are:**

- Physicians

- Podiatrists
- Psychologists
- Certified Clinical Nurse Specialists
- Certified Nurse-Midwives
- Certified Nurse Practitioners
- Certified Registered Nurse Anesthetists
- Chiropractors
- Clinical Laboratories
- Clinical Professional Counselors
- Clinical Social Workers
- Durable Medical Equipment Providers
- Home Infusion Therapy Providers
- Marriage and Family Therapists
- Occupational Therapists[
- Optometrists][
- Orthotic Providers]
- Physical Therapists[
- Prosthetic Providers][
- Registered Surgical Assistants][
- Retail Health Clinics]
- Speech Therapists

who have signed an Agreement with Blue Cross and Blue Shield to accept the Maximum Allowance as payment in full. Such [Community Providers and]Participating Providers have agreed not to bill you for Covered Services amounts in excess of the Maximum Allowance. Therefore, you will be responsible only for the difference between the Blue Cross and Blue Shield benefit payment and the Maximum Allowance for the particular Covered Service — that is, your program deductible, Copayment and Coinsurance amounts.

Non-Participating Providers are:

- Physicians
- Podiatrists
- Psychologists
- Dentists
- Certified Clinical Nurse Specialists
- Certified Nurse-Midwives

- Certified Nurse Practitioners
- Certified Registered Nurse Anesthetists
- Chiropractors
- Clinical Laboratories
- Clinical Professional Counselors
- Clinical Social Workers
- Durable Medical Equipment Providers
- Home Infusion Therapy Providers
- Marriage and Family Therapists
- Occupational Therapists[
- Optometrists][
- Orthotic Providers]
- Physical Therapists[
- Prosthetic Providers][
- Registered Surgical Assistants][
- Retail Health Clinics]
- Speech Therapists
- other Professional Providers

who have not signed an agreement with Blue Cross and Blue Shield to accept the Maximum Allowance as payment in full. Therefore, you are responsible to these Providers for the difference between the Blue Cross and Blue Shield benefit payment and such Provider's charge to you.

Should you wish to know the Maximum Allowance for a particular procedure or whether a particular Provider is a [Community Provider or]Participating Provider, contact your Group Administrator, your Professional Provider or Blue Cross and Blue Shield.]

SPECIAL CONDITIONS AND PAYMENTS

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

HUMAN ORGAN TRANSPLANTS

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

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

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

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

Benefits will be provided for:

— Inpatient and Outpatient Covered Services related to the transplant Surgery.

— the evaluation, preparation and delivery of the donor organ.

— the removal of the organ from the donor.

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

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

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

— If 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 [30–200] miles from the Hospital where the transplant will be performed. 22.72

- [You and your companion are each entitled to benefits for lodging and meals up to a combined maximum of $[100–5,000] per day.] 22.721a
- [You and your companion are each entitled to benefits for lodging up to a combined maximum of $[100–5,000] per day.] 22.721b
- [Benefits for transportation, lodging and meals are limited to a maximum of $[1,000–30,000] per transplant.] 22.722a
- [Benefits for transportation, lodging and meals are limited to a lifetime maximum of $[1,000–30,000].] 22.722b

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

- Cardiac rehabilitation services when not provided to the transplant recipient immediately following discharge from a Hospital for transplant Surgery.
- Travel time and related expenses required by a Provider.
- Drugs which do not have approval of the Food and Drug Administration.
- Storage fees.
- Services provided to any individual who is not the recipient or actual donor, unless otherwise specified in this provision.

Your benefits for heart, lung, heart/lung, liver, pancreas and pancreas/kidney transplants are subject to a lifetime maximum of $[250,000–10,000,000]. This lifetime maximum is separate from your lifetime maximum for all other benefits. 22.61

CARDIAC REHABILITATION SERVICES

Your benefits for cardiac rehabilitation services are the same as your benefits for any other condition. Benefits will be provided for cardiac rehabilitation services only in Blue Cross and Blue Shield approved programs. Benefits are available if you have a history of any of the following: acute myocardial infarction, coronary artery bypass graft Surgery, percutaneous transluminal coronary angioplasty, heart valve Surgery, heart transplantation, stable angina pectoris, compensated heart failure or transmyocardial revascularization. Benefits will be limited to a maximum of 36 Outpatient treatment sessions within the six month period.

[WELLNESS CARE

[Benefits will be provided for Covered Services rendered to persons age [one–21] and over, even though you are not ill. Benefits will be limited to the following services:] 22.56a

[Benefits will be provided for Covered Services rendered to you, even though you are not ill. Benefits will be limited to the following services:] 22.56b

1. Immunizations[for children under age [one–21]]; 22.566
2. Routine physical examinations[– [one, 2] per benefit period]; 22.567
3. [Routine gynecological examinations[– [one, 2] per benefit period];] 22.5671 22.56711

4. [Routine vision examinations[– [one, 2] per benefit period];] 22.5672 22.56721
5. Routine diagnostic tests[ordered or received on the same day as the examination]. 22.568

[**Community Provider**

When you receive Covered Services for wellness care from a Community Provider[(other than in a Physician's office)], benefits for wellness care will be provided at [[50–100]% of the Eligible Charge[or [50–100]% of the Maximum Allowance]][the Community Provider payment level specified in the Benefit Highlights (an insert) of this Certificate] and will not be subject to the program deductible.

[**When you receive Covered Services for wellness care in your Physician's office, benefits for office visits are subject to [a Copayment of $[5–100] per visit][the Physician's office Copayment amount specified in the Benefit Highlights (an insert) of this Certificate]. Benefits for office visits will then be provided at [[50–100]% of the Maximum Allowance][the Physician's office visit payment level specified in the Benefit Highlights (an insert) of this Certificate][after you have met your program deductible].[Your program deductible will not apply.]** 22.561CPOa 22.561CPOb 22.561CPOc 22.561CPOd 22.561CPO

[**When you receive Covered Services for wellness care in your Physician's office, benefits for Covered Services will be provided at [50–100]% of the Maximum Allowance and are subject to [a Copayment of $[5–100] per visit][the Community Provider office payment level specified in the Benefit Highlights (an insert) of this Certificate]. Your program deductible will not apply.]** 22.562CPOa 22.562CPOb 22.562CPO

For Covered Services for wellness care you receive from a Provider other than a Community Provider, benefit payment will be as described below.] 22.56CPO

Participating Provider

[When you receive Covered Services for wellness care from a Participating Provider[other than in a Physician's office], benefits for wellness care will be provided at [50–100]% of the Eligible Charge or [50–100]% of the Maximum Allowance[after you have met your program deductible][and will not be subject to the program deductible].] 22.5611a 22.561 22.562

[When you receive Covered Services for wellness care from a Participating Provider[other than in a Physician's office], benefits for wellness care will be provided at the Participating Provider payment level [for Hospital Outpatient Covered Services or Surgical/Medical Covered Services]specified in the Benefit Highlights (an insert) of this Certificate [after you have met your program deductible][and will not be subject to the program deductible].] 22.5611b 22.561 22.562

[Benefits for routine diagnostic tests received from a Participating Provider will be provided at [50–100]% of the Eligible Charge or Maximum Allowance and will not be subject to the program deductible or Copayment.] 22.569

[When you receive Covered Services other than certain diagnostic tests for wellness care in a Participating Professional Provider's office, benefits for Covered Services will be provided at [[50–100]% of the Maximum Allowance and are subject to a Copayment of $[5–100] per visit][the Participating Provider's office payment level 22.565a2 22.565a3

specified in the Benefit Highlights (an insert) of this Certificate]. Such diagnostic tests include MRI, CT Scan[, EKG, EEG, ECG] and pulmonary function studies.] 22.565a 22.565a1

[When you receive Covered Services for wellness care in a Participating Professional Provider's office, benefits for office visits are subject to[a Copayment of $[5–100] per visit][the Physician's office Copayment amount specified in the Benefit Highlights (an insert) of this Certificate]. Benefits for office visits will then be provided at [[50–100]% of the Maximum Allowance][the Physician's office visit payment level specified in the Benefit Highlights (an insert) of this Certificate][after you have met your program deductible].[Your program deductible will not apply.]] 22.565b1 22.565b2 22.565b 22.565b3 22.565b4

[When you receive Covered Services for wellness care in a Participating Professional Provider's office, benefits for Covered Services will be provided at [50–100]% of the Maximum Allowance and are subject to a Copayment of $[5–100] per visit.] 22.565c

[When you receive Covered Services for wellness care in a Participating Professional Provider's office, benefits for Covered Services will be provided at [50–100]% of the Maximum Allowance and are subject to the Physician office Copayment specified in the Benefit Highlights (an insert) of this Certificate.] 22.565d

Non-Participating Provider

[When you receive Covered Services for wellness care from a Non-Participating Provider, benefits will be provided at [50–100]% of the Eligible Charge or [50–100]% of the Maximum Allowance [after you have met your program deductible][and will not be subject to the program deductible].] 22.5611a 22.561NP 22.562NP

[When you receive Covered Services for wellness care from a Non-Participating Provider, benefits for wellness care will be provided at the Non-Participating Provider payment level [for Surgical/Medical Covered Services]specified in the Benefit Highlights (an insert) of this Certificate [after you have met your program deductible][and will not be subject to the program deductible].] 22.5611b 22.561NP 22.562NP

[When you receive Covered Services for wellness care other than certain diagnostic tests for wellness care in a Non-Participating Professional Provider's office, benefits for Covered Services will be provided at [[50–100]% of the Maximum Allowance and are subject to a Copayment of $[5–100] per visit][the Non-Participating Provider's office payment level specified in the Benefit Highlights (an insert) of this Certificate]. Such diagnostic tests include MRI, CT Scan[, EKG, EEG, ECG,] and pulmonary function studies.] 22.563a2 22.563a3 22.563a 22.563a1

[When you receive Covered Services for wellness care in a Non-Participating Professional Provider's office, benefits for office visits are subject to[a Copayment of $[5–100] per visit][the Physician's office Copayment amount specified in the Benefit Highlights (an insert) of this Certificate].] 22.563b 22.563b1 22.563b2

[When you receive Covered Services for wellness care in a Non-Participating Professional Provider's office, benefits for Covered Services will be provided at [50–100]% of the Maximum Allowance and are subject to a Copayment of $[5–100] per visit.] 22.563c

[When you receive Covered Services for wellness care in a Non-Participating Professional Provider's office, benefits for Covered Services will be provided at [50–100]% of the Maximum Allowance and are subject to the Physician office Copayment specified in the Benefit Highlights (an insert) of this Certificate.] 22.563d

[**Wellness Care Benefit Maximum**

Benefits for wellness care will be limited to a maximum of $[100–5,000] per benefit period[when you receive Covered Services from a Non-Participating Provider]. 22.564 22.5641

The following Covered Services are not subject to the wellness care benefit maximum: routine mammogram, Pap smear test, prostate test and digital rectal examination, colorectal cancer screening, ovarian cancer screening, clinical breast examination, and human papillomavirus vaccine.]] 22.564 22.56

SKILLED NURSING FACILITY CARE

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

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

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.

[Benefits for Covered Services rendered in a Plan Skilled Nursing Facility will be provided at [50–100]% of the Eligible Charge[after you have met your program deductible].] 22.42a

[Benefit payment for Covered Services rendered by a Plan Skilled Nursing Facility will be provided at the same payment level as specified in the Benefit Highlights (an insert) of this Certificate for Participating Hospital Inpatient Covered Services.] 22.42b

[Benefits for Covered Services rendered in a Non-Plan Skilled Nursing Facility will be provided at [50–100]% of the Eligible Charge, once you have met your program deductible. Benefits will not be provided for Covered Services received in an Uncertified Skilled Nursing Facility.] 22.431 22.43

[Each time you are admitted to a Skilled Nursing Facility, you are entitled to benefits for [5–365] days of care.] 22.421a

[You are entitled to benefits for [5–365] days of care in a Skilled Nursing Facility per benefit period.] 22.421b

[Your benefits for Skilled Nursing Facility Care are combined with your benefits for [Private Duty Nursing][and Coordinated Home Care]. The maximum amount of benefits that will be provided for Skilled Nursing Facility Care[, Private Duty Nursing][and Coordinated Home Care] is a combined maximum of $[500–100,000] per benefit period.] 22.421c

AMBULATORY SURGICAL FACILITY

Benefits for all of the Covered Services previously described in this Certificate are available for Outpatient Surgery. In addition, benefits will be provided if these services are rendered by an Ambulatory Surgical Facility.

[Benefits for services rendered by a Plan Ambulatory Surgical Facility will be provided at [50–100]% of the Eligible Charge. Benefits for services by a Non-Plan Ambulatory Surgical Facility will be provided at [50–100]% of the Eligible Charge.] 22.44a

[Benefit payment for Covered Services rendered by a Plan Ambulatory Surgical Facility will be provided at the same payment level as specified in the Benefit Highlights (an insert) of this Certificate for Participating Hospital Outpatient Surgery. Benefits for services by a Non-Plan Ambulatory Surgical Facility will be provided at 50% of the Eligible Charge.] 22.44b

[Benefits for Outpatient Surgery will be provided as stated above whether or not you have met your program deductible.] 22.441

[Benefits for Outpatient Surgery will be provided as stated above after you have met your program deductible.] 22.442

[SUBSTANCE ABUSE REHABILITATION TREATMENT] 22.4SA **Revised**

[Benefits for all of the Covered Services described in this Certificate are available for Substance Abuse Rehabilitation Treatment. In addition, benefits will be provided if these Covered Services are rendered by a Substance Abuse Treatment Facility. Benefits will be provided at the payment levels described later in this benefit section. Substance Abuse Rehabilitation Treatment Covered Services rendered in a program that does not have a written agreement with Blue Cross and Blue Shield or in a Non-Plan Provider facility will be paid at the Non-Plan Provider facility payment level described later in this benefit section.] 22.68 **Revised – prior to 10/3/09 or MHP does not apply**

[Your benefits for Substance Abuse Rehabilitation Treatment are the same as your benefits for any other condition. In addition, benefits will be provided if Covered Services are rendered by a Substance Abuse Treatment Facility. Substance Abuse Rehabilitation Treatment Covered Services rendered in a program that does not have a written agreement with Blue Cross and Blue Shield or in a Non-Plan Provider facility will be paid at the Non-Plan Provider facility payment level.] 22.9b **New – MHP 10/3/09–7/1/10**

[SUBSTANCE ABUSE REHABILITATION TREATMENT

Benefits for all of the Covered Services described in this Certificate are available for Substance Abuse Rehabilitation Treatment. In addition, benefits will be provided if these Covered Services are rendered by a Behavioral Health Practitioner in a Substance Abuse Treatment Facility. Substance Abuse Rehabilitation Treatment Covered Services rendered in a program that does not have a written agreement with Blue Cross and Blue Shield or in a Non-Plan Provider facility will be paid at the Non-Plan Provider facility payment level.][22.9a **Revised – MHP Final Regs 7/1/10 & after**

[MENTAL ILLNESS SERVICES] 22.4MI **Revised**

Benefits for all of the Covered Services described in this Certificate are available for the diagnosis and/or treatment of a Mental Illness. Medical Care for the treatment of a Mental Illness is eligible when rendered by (1) a Physician; (2) a Psychologist; (3) a Clinical Social Worker; (4) a Clinical Professional Counselor or (5) a Marriage and Family Therapist working within the scope of their license.] 22.68 **Revised – prior to 10/3/09 or MHP does not apply**

[Your benefits for the diagnosis and/or treatment of a Mental Illness are the same as your benefits for any other condition. Medical Care for the treatment of a Mental Illness is eligible when rendered by (1) a Physician; (2) a Psychologist; (3) a Clinical Social Worker; (4) a Clinical Professional Counselor or (5) a Marriage and Family Therapist working within the scope of their license.] 22.9b **New – MHP 10/3/09–7/1/10**

[**MENTAL ILLNESS AND SUBSTANCE ABUSE SERVICES**

Benefits for all of the Covered Services described in this Certificate are available for the diagnosis and/or treatment of a Mental Illness and/or Substance Abuse disorders. Medical Care for the treatment of a Mental Illness or Substance Abuse disorder is eligible when rendered by a Behavioral Health Practitioner working within the scope of their license.]

22.9a **Revised – MHP Final Regs 7/1/10 & after**

[**CHRONIC CONDITION MANAGEMENT**

Benefits will be provided for services for the management of prescription drugs prescribed as part of psychiatric care, including the prescription, use and review of medication with no more than minimal medical psychotherapy.]

22.68b

[**Benefit Payment for treatment of Mental Illness and Substance Abuse Rehabilitation Treatment from a Community Provider**

After you have met your program deductible, benefits for Outpatient treatment of Serious Mental Illness will be provided at the payment levels previously described in this Certificate for Hospital and Physician Covered Services received from a Community Provider[after you have met your program deductible].

22.46CPO

After you have met your program deductible, benefits for Outpatient Mental Illness treatment for those illnesses not classified as Serious Mental Illness will be provided at [[50–100]% of the Eligible Charge[or at [50–100]% of the Maximum Allowance]][the Community Provider payment level specified in the Benefit Highlights (an insert) to this Certificate] when you receive services from a Community Provider.]

22.46CPO

[**After you have met your program deductible, benefits for Outpatient Substance Abuse Rehabilitation Treatment (in a program that has a written agreement with Blue Cross and Blue Shield) will be provided at [[50–100]% of the Eligible Charge[or at [50–100]% of the Maximum Allowance]] [the Community Provider payment level specified in the Benefit Highlights (an insert) to this Certificate] when you receive services from a Community Provider.]**

22.47CPO

[**After you have met your program deductible, Hospital benefits for the Inpatient treatment of Mental Illness for those illnesses not classified as Serious Mental Illness and Inpatient Substance Abuse Rehabilitation Treatment (in a program that has a written agreement with Blue Cross and Blue Shield in a Community Provider Hospital) will be provided at [[50–100]% of the Eligible Charge][the Community Provider payment level specified in the Benefit Highlights (an insert) to this Certificate] for the first [5–365] days of each admission. Any remaining eligible Hospital charges will be paid at 50% of the Eligible Charge.]**

22.531aCPO

[**After you have met your program deductible, Hospital benefits for the Inpatient treatment of Mental Illness for those illnesses not classified as Serious Mental Illness and Inpatient Substance Abuse Rehabilitation Treatment (in a program that has a written agreement with Blue Cross and Blue Shield in a Community Provider Hospital) will be provided at [[50–100]% of the Eligible Charge][the Community Provider payment level specified in the Benefit Highlights (an insert) to this Certificate].]**

22.531bCPO

[When you receive Covered Services for the Inpatient treatment of Mental Illness for those illnesses not classified as Serious Mental Illness or Inpatient Substance Abuse Rehabilitation Treatment from a Professional Provider who is a Community Provider, benefits will be provided at [50–100]% of the Maximum Allowance after you have met your program deductible.]

For Covered Services for the treatment of Mental Illness and Substance Abuse Rehabilitation Treatment you receive from a Provider other than a Community Provider, benefit payment will be as described below.] 22.531CPO

[Benefit Payment for Outpatient treatment of Mental Illness and Substance Abuse Rehabilitation Treatment

Benefits for Outpatient treatment of Serious Mental Illness will be provided at the payment levels previously described in this Certificate for Hospital and Physician Covered Services. 22.68a

[Benefits for Outpatient treatment of Mental Illness for those illnesses not classified as Serious Mental Illness will be provided at [[50–100]% of the Eligible Charge or at [50–100]% of the Maximum Allowance][the Participating Provider payment levels specified in the Benefit Highlights (an insert) of this Certificate][after you have met your program deductible]when you receive services from a Participating Provider.] 22.46a3 22.46a31

[When you receive Covered Services in a Participating Provider's office for the Outpatient treatment of Mental Illness for those illnesses not classified as Serious Mental Illness, benefits for office visits are subject to a Copayment of $[5–100] per visit. Benefits for office visits will be provided at [50–100]% of the Maximum Allowance[after you have met your program deductible].[Your program deductible will not apply.]] 22.46a1 22.46a11 22.46a12

[When you receive Covered Services in a Participating Provider's office, benefits for the Outpatient treatment of Mental Illness for those illnesses not classified as Serious Mental Illness are subject to a Copayment of $[5–100] per visit. Benefits will then be provided at [50–100]% of the Maximum Allowance[after you have met your program deductible].[Your program deductible will not apply.] 22.46a2 22.46a21 22.46a22

[When you receive Covered Services from a Non-Participating Provider for Outpatient treatment of Mental Illness for those illnesses not classified as Serious Mental Illness, benefits will be provided at [[50–100]% of the Eligible Charge or [50–100]% of the Maximum Allowance][the Non-Participating Provider payment levels specified in the Benefit Highlights (an insert) of this Certificate] after you have met your program deductible.] 22.46a3 22.46a31 22.46a

[When you receive Covered Services in a Non-Participating Provider's office, benefits for Outpatient Substance Abuse Rehabilitation Treatment are subject to a Copayment of $[5–100] per visit. Benefits will then be provided at [50–100]% of the Maximum Allowance[after you have met your program deductible].[Your program deductible will not apply.] 22.47b2

[Benefits for Outpatient treatment of Mental Illness for those illnesses not classified as Serious Mental Illness will be provided at [50–100]% of the Eligible Charge or at [50–100]% of the Maximum Allowance for the first [5–365] visits per benefit period after you have met your program deductible], thereafter benefits will be provided at

50% of the Eligible Charge or at 50% of the Maximum Allowance when you receive services from a Participating Provider.]

[When you receive Covered Services in a Participating Provider's office for the Outpatient treatment of Mental Illness for those illnesses not classified as Serious Mental Illness, benefits for office visits are subject to a Copayment of $[5–100] per visit. Benefits for office visits will be provided at [50–100]% of the Maximum Allowance[after you have met your program deductible].[Your program deductible will not apply.]] 22.46b1 22.46b11 22.46b12

[When you receive Covered Services in a Participating Provider's office, benefits for the Outpatient treatment of Mental Illness for those illnesses not classified as Serious Mental Illness are subject to a Copayment of $[5–100] per visit. Benefits will then be provided at [50–100]% of the Maximum Allowance[after you have met your program deductible].[Your program deductible will not apply.] 22.46b2 22.46b21 22.46b22

[When you receive Covered Services from a Non-Participating Provider for Outpatient treatment of Mental Illness for those illnesses not classified as Serious Mental Illness, benefits will be provided at [50–100]% of the Eligible Charge or [50–100]% of the Maximum Allowance for the first [5–365] visits per benefit period after you have met your deductible, thereafter benefits will be provided at 50% of the Eligible Charge or at 50% of the Maximum Allowance after you have met your program deductible.] 22.46b

[When you receive Covered Services in a Non-Participating Provider's office, benefits for the Outpatient treatment of Mental Illness for those illnesses not classified as Serious Mental Illness are subject to a Copayment of $[5–100] per visit. Benefits will then be provided at [50–100]% of the Maximum Allowance[after you have met your program deductible].[Your program deductible will not apply.] 22.46b2

[Benefits for Outpatient Substance Abuse Rehabilitation Treatment (in a program that has a written agreement with Blue Cross and Blue Shield) will be provided at [[50–100]% of the Eligible Charge or at [50–100]% of the Maximum Allowance][the Participating Provider payment levels specified in the Benefit Highlights (an insert) of this Certificate][after you have met your program deductible]when you receive services from a Participating Provider or Plan Provider facility.] 22.47a3 22.47a31

[When you receive Covered Services in a Participating Provider's office for Outpatient Substance Abuse Rehabilitation Treatment, benefits for office visits are subject to a Copayment of $[50–100] per visit. Benefits for office visits will be provided at [50–100]% of the Maximum Allowance[after you have met your program deductible].[Your program deductible will not apply.]] 22.47a1 22.47a11 22.47a12

[When you receive Covered Services in a Participating Provider's office, benefits for Outpatient Substance Abuse Rehabilitation Treatment are subject to a Copayment of $[5–100] per visit. Benefits will then be provided at [50–100]% of the Maximum Allowance[after you have met your program deductible].[Your program deductible will not apply.] 22.47a2 22.47a21 22.47a22

[When you receive Covered Services from a Non-Participating Provider for Outpatient Substance Abuse Rehabilitation Treatment (in a program that has a written agreement with Blue Cross and Blue Shield), benefits will be provided at [[50–100]% of the Eligible Charge or [50–100]% of the Maximum Allowance][the Non-Partici- 22.47a3 22.47a31

pating Provider payment levels specified in the Benefit Highlights (an insert) of this Certificate] after you have met your program deductible.] 22.47a

[When you receive Covered Services in a Non-Participating Provider's office, benefits for Outpatient Substance Abuse Rehabilitation Treatment are subject to a Copayment of $[5–100] per visit. Benefits will then be provided at [50–100]% of the Maximum Allowance[after you have met your program deductible].[Your program deductible will not apply.] 22.47b2

[Benefits for Outpatient Substance Abuse Rehabilitation Treatment (in a program that has a written agreement with Blue Cross and Blue Shield) will be provided at [50–100]% of the Eligible Charge or at [50–100]% of the Maximum Allowance for the first [5–365] visits per benefit period[after you have met your program deductible], thereafter benefits will be provided at 50% of the Eligible Charge or at 50% of the Maximum Allowance when you receive services from a Participating Provider or Plan Provider facility.]

[When you receive Covered Services in a Participating Provider's office for Outpatient Substance Abuse Rehabilitation Treatment, benefits for office visits are subject to a Copayment of $[50–100] per visit. Benefits for office visits will be provided at [50–100]% of the Maximum Allowance[after you have met your program deductible].[Your program deductible will not apply.]] 22.47b1 22.47b11 22.47b12

[When you receive Covered Services in a Participating Provider's office, benefits for Outpatient Substance Abuse Rehabilitation Treatment are subject to a Copayment of $[5–100] per visit. Benefits will then be provided at [50–100]% of the Maximum Allowance[after you have met your program deductible].[Your program deductible will not apply.] 22.47b2 22.47b21 22.47b22

[When you receive Covered Services from a Non-Participating Provider for Outpatient Substance Abuse Rehabilitation Treatment (in a program that has a written agreement with Blue Cross and Blue Shield), benefits will be provided at [50–100]% of the Eligible Charge or [50–100]% of the Maximum Allowance for the first [5–365] visits per benefit period after you have met your deductible, thereafter benefits will be provided at 50% of the Eligible Charge or at 50% of the Maximum Allowance.] 22.47b

[When you receive Covered Services in a Non-Participating Provider's office, benefits for Outpatient Substance Abuse Rehabilitation Treatment are subject to a Copayment of $[5–100] per visit. Benefits will then be provided at [50–100]% of the Maximum Allowance[after you have met your program deductible].[Your program deductible will not apply.] 22.47b2

[Benefit Maximum for Outpatient [treatment of Mental Illness][and][Substance Abuse Rehabilitation Treatment] 22.471

[Your benefits for Outpatient treatment of Serious Mental Illness are limited to a maximum of [35–365] visits per benefit period.] 22.471d

[Your benefits for Outpatient treatment of Mental Illness for those illness not classified as Serious Mental Illness and Outpatient Substance Abuse Rehabilitation Treatment are limited to a combined maximum of [5–365] visits per benefit period.] 22.471b

[Your benefits for Outpatient treatment of Mental Illness for those illnesses not classified as Serious Mental Illness are limited to a maximum of [5–365] visits per benefit period.] 22.471c

[Your benefits for Outpatient Substance Abuse Rehabilitation Treatment are limited to a maximum of [5–365] visits per benefit period.] 22.471c1

[Your benefits for Outpatient Substance Abuse Rehabilitation Treatment are limited to a maximum of $[500–100,000] per benefit period.]] 22.471c2

Benefit Payment for Inpatient treatment of Mental Illness and Substance Abuse Rehabilitation Treatment

Benefits for the Inpatient treatment of Serious Mental Illness will be provided at the payment levels previously described in this Certificate for Hospital and Physician Covered Services.

[Benefits for the Inpatient treatment of Mental Illness for those illnesses not classified as Serious Mental Illness and Inpatient Substance Abuse Rehabilitation Treatment will be provided at the payment levels previously described in this Certificate for Hospital and Physician Covered Services.] 22.53a

[Benefits for the Inpatient treatment of Mental Illness for those illnesses not classified as Serious Mental Illness and Inpatient Substance Abuse Rehabilitation Treatment (in a program that has a written agreement with Blue Cross and Blue Shield) in a Participating Hospital or a Plan Facility will be provided at [[50–100]% of the Eligible Charge][the Participating Provider payment level specified in the Benefit Highlights (an insert) of this Certificate] for the first [5–365] days of each admission[after your program deductible][and your Inpatient Hospital admission deductible], thereafter any remaining eligible Hospital charges will be paid at 50% of the Eligible Charge.] 22.53b1 22.53b2 22.531a

[Benefits for the Inpatient treatment of Mental Illness for those illnesses not classified as Serious Mental Illness and Inpatient Substance Abuse Rehabilitation Treatment (in a program that has a written agreement with Blue Cross and Blue Shield) in a Participating Hospital or a Plan Facility will be provided at [[50–100]% of the Eligible Charge][the Participating Provider payment level specified in the Benefit Highlights (an insert) of this Certificate][after your program deductible].] 22.53b1 22.53b2 22.531b

[Benefits for the Inpatient treatment of Mental Illness for those illnesses not classified as Serious Mental Illness and Inpatient Substance Abuse Rehabilitation Treatment (in a program that has a written agreement with Blue Cross and Blue Shield) in a Non-Participating Hospital will be provided at [[50–100]% of the Eligible Charge][the Non-Participating Provider payment level specified in the Benefit Highlights (an insert) of this Certificate] for the first [5–365] days of each admission after your program deductible[and your Inpatient Hospital admission deductible], thereafter any remaining eligible Hospital charges will be paid at 50% of the Eligible Charge.] 22.53b1 22.53b2 22.532a

[Benefits for the Inpatient treatment of Mental Illness for those illnesses not classified as Serious Mental Illness and Inpatient Substance Abuse Rehabilitation Treatment (in a program that has a written agreement with Blue Cross and Blue Shield) in a Non-Participating Hospital will be provided at [[50–100]% of the Eligible Charge][the Non-Participating Provider payment level specified in the Benefit Highlights (an in- 22.53b1 22.53b2

sert) of this Certificate] after you have met your program deductible[and your Inpatient Hospital admission deductible].] 22.532b

[When you receive Covered Services for the Inpatient treatment of Mental Illness for those illnesses not classified as Serious Mental Illness or Inpatient Substance Abuse Rehabilitation Treatment from a Participating Professional Provider, benefits will be provided at [[50–100]% of the Maximum Allowance][the Participating Provider payment level for Surgical/Medical Covered Services specified in the Benefit Highlights (an insert) of this Certificate][after you have met your program deductible].] 22.53b1 22.53b2 22.534

[When you receive Covered Services for the Inpatient treatment of Mental Illness for those illnesses not classified as Serious Mental Illness or Inpatient Substance Abuse Rehabilitation Treatment from a Non-Participating Professional Provider, benefits will be provided at [[50–100]% of the Maximum Allowance][the Non-Participating Provider payment level for Surgical/Medical Covered Services specified in the Benefit Highlights (an insert) of this Certificate] after you have met your program deductible.] 22.53b1 22.53b2 22.534 22.53b

[Benefit Maximum for [Inpatient treatment of Mental Illness][and][Substance Abuse Rehabilitation Treatment]

[You are entitled to a maximum of [45–365] Inpatient Hospital days each benefit period for Inpatient treatment of Serious Mental Illness.] 22.48d

[You are entitled to a combined maximum of [5–365] Inpatient Hospital days each benefit period for Inpatient treatment of Mental Illness for those illnesses not classified as Serious Mental Illness and Inpatient Substance Abuse Rehabilitation Treatment.] 22.48a

[You are entitled to a maximum of [5–365] Inpatient Hospital days each benefit period for Inpatient treatment of Mental Illness for those illnesses not classified as Serious Mental Illness.] 22.48b

[You are entitled to a maximum of [5–365] Inpatient Hospital days each benefit period for Inpatient Substance Abuse Rehabilitation Treatment.] 22.48b1

[Your benefits for Inpatient Substance Abuse Rehabilitation Treatment are limited to a maximum of $[500–750,000] each benefit period.]] 22.48b2

[Lifetime Benefit Maximum for [treatment of Mental Illness][and][Substance Abuse Rehabilitation Treatment]

[You are entitled to a combined lifetime maximum of [10–1,000] Inpatient Hospital days for Inpatient treatment of Mental Illness for those illnesses not classified as Serious Mental Illness and Substance Abuse Rehabilitation Treatment]. 22.491

[You are entitled to a lifetime maximum of [10–1,000] Inpatient Hospital days for Inpatient treatment of Mental Illness for those illnesses not classified as Serious Mental Illness.] 22.496

[You are entitled to a lifetime maximum of [10–1,000] Inpatient Hospital days for Inpatient Substance Abuse Rehabilitation Treatment.] 22.497a

[A lifetime maximum of $[500–750,000] will apply to benefits for Inpatient Substance Abuse Rehabilitation Treatment.] 22.497b

[You are entitled to a combined lifetime maximum of [10–1,000] Outpatient visits for Outpatient treatment of Mental Illness for those illnesses not classified as Serious Mental Illness and Substance Abuse Rehabilitation Treatment.] 22.492

[You are entitled to a lifetime maximum of [10–1,000] Outpatient visits for Outpatient treatment of Mental Illness for those illnesses not classified as Serious Mental Illness.] 22.494

[You are entitled to a lifetime maximum of [10–1,000] Outpatient visits for Outpatient Substance Abuse Rehabilitation Treatment.] 22.495a

[A lifetime maximum of $[500–750,000] will apply to benefits for Outpatient Substance Abuse Rehabilitation Treatment.] 22.495b

[A combined lifetime maximum of $[500–750,000] will apply to benefits for Inpatient and Outpatient Substance Abuse Rehabilitation Treatment.]] 22.493

[None of the charges for the Inpatient and/or Outpatient treatment of Mental Illness for those illnesses not classified as Serious Mental Illness or Substance Abuse Rehabilitation Treatment will be included in the calculation of your out-of-pocket expenses.] 22.517

[BENEFIT PAYMENT FOR MENTAL ILLNESS, SUBSTANCE ABUSE REHABILITATION TREATMENT AND CHRONIC CONDITION MANAGEMENT

Your benefits for the treatment of Mental Illness, Substance Abuse Rehabilitation treatment and Chronic Condition Management are determined differently than the other benefits described in this Certificate. The benefit payment for the treatment of Mental Illness, Substance Abuse Rehabilitation treatment and Chronic Condition Management will be determined at the In-Network or Out-of-Network payment level.

Prior to receiving Covered Services for the treatment of Mental Illness, Substance Abuse Rehabilitation treatment or Chronic Condition Management you must, in order to receive maximum In-Network benefits, contact the Blue Cross and Blue Shield Mental Health Unit at 1-800-851-7498. When you contact the Blue Cross and Blue Shield Mental Health Unit, you will be referred to a specific Professional Provider for treatment.

Benefits for the treatment of Mental Illness, Substance Abuse Rehabilitation Treatment and Chronic Condition Management will be provided at the In-Network payment level only if you contact the Blue Cross and Blue Shield Mental Health Unit prior to receiving Covered Services and receive Covered Services from the Professional Provider to whom you have been referred by the Blue Cross and Blue Shield Mental Health Unit.

Benefits for the treatment of Mental Illness, Substance Abuse Rehabilitation Treatment and Chronic Condition Management will be provided at the Out-of-Network payment level if you contact the Blue Cross and Blue Shield Mental Health Unit but do not receive Covered Services from the Professional Provider to whom you have been referred by the Blue Cross and Blue Shield Mental Health Unit.

If you do not contact the Blue Cross and Blue Shield Mental Health Unit prior to receiving Covered Services for the treatment of Mental Illness, Substance Abuse Rehabilitation Treatment and Chronic Condition Management, benefits will be reduced by $[100–5,000] and paid at the Out-of-Network payment level.

Outpatient Mental Illness Treatment

Benefits for the Outpatient treatment of Serious Mental Illness will be provided at the Participating Provider payment levels previously described in this Certificate for Hospital and Physician Covered Services when you receive Covered Services In-Network.

After you have met your program deductible, benefits for Outpatient treatment of Mental Illness for those illnesses not classified as Serious Mental Illness will be provided at [50–100]% of the Eligible Charge or at [50–100]% of the Maximum Allowance when you receive Covered Services In-Network. 22.681

Benefits for the Outpatient treatment of Serious Mental Illness will be provided at the Non-Participating Provider payment levels previously described in this Certificate for Hospital and Physician Covered Services when you receive Covered Services Out-of-Network.

After you have met your program deductible, benefits for Outpatient treatment for those illnesses not classified as Serious Mental Illness will be provided at [50–100]% of the Eligible Charge or [50–100]% of the Maximum Allowance when you receive Covered Services Out-of-Network. 22.682

[Your benefits for Outpatient treatment of Serious Mental Illness are limited to a maximum of [35–365] visits per benefit period. However, persons age 18 and under are entitled to [35–365] visits per benefit period for the Outpatient treatment of Serious Mental Illness.] 22.6831

[Your benefits for Outpatient treatment of Mental Illness for those illnesses not classified as Serious Mental Illness are limited to a maximum of [30–365] visits per benefit period. However, persons age 18 and under are entitled to [30–365] visits per benefit period for the Outpatient treatment of Mental Illness for those illnesses not classified as Serious Mental Illness.] 22.683

[**Outpatient Substance Abuse Rehabilitation Treatment**

After you have met your program deductible, benefits for Outpatient Substance Abuse Rehabilitation Treatment will be provided at [50–100]% of the Eligible Charge or at [50–100]% of the Maximum Allowance when you receive Covered Services In-Network. 22.684

When you receive Covered Services (in a program that has a written agreement with Blue Cross and Blue Shield) Out-of-Network for Outpatient Substance Abuse Rehabilitation Treatment, benefits will be provided at [50–100]% of the Eligible Charge or [50–100]% of the Maximum Allowance after you have met your program deductible. 22.685

Benefits for Out-of-Network Substance Abuse Rehabilitation Treatment in a program that does not have a written agreement with Blue Cross and Blue Shield or in a Non-Plan Provider facility will be provided at 50% of the Eligible Charge after you have met your program deductible.

[Your benefits for Outpatient Substance Abuse Rehabilitation Treatment are limited to a maximum of [30–365] visits per benefit period. However, persons age 18 and under are entitled to a maximum of [30–365] visits per benefit period for Outpatient Substance Abuse Rehabilitation Treatment.]] 22.686

[**Chronic Condition Management**

Benefits for the treatment of Chronic Condition Management will be provided at [50–100]% of the Eligible Charge or at [50–100]% of the Maximum Allowance after you have met your program deductible when you receive Covered Services In-Network. When you receive Covered Services Out-of-Network for the treatment of Chronic Condition Management, benefits will be provided at [50–100]% of the Eligible Charge or [50–100]% of the Maximum Allowance after you have met your program deductible.

Your benefits for the treatment of Chronic Condition Management are limited to one visit each month.] 22.687

[**Inpatient Mental Illness and Substance Abuse Rehabilitation Treatment**

Benefits for the Inpatient treatment of Serious Mental Illness will be provided at the Participating Provider payment levels previously described in this Certificate for Hospital and Physician Covered Services when you receive Covered Services In-Network.

Benefits for the Inpatient treatment of Mental Illness for those illnesses not classified as Serious Mental Illness and Inpatient Substance Abuse Rehabilitation Treatment will be provided at [50–100]% of the Eligible Charge or at [50–100]% of the Maximum Allowance when you receive Covered Services In-Network[after you have met your program deductible]. 22.688

Benefits for the Inpatient treatment of Serious Mental Illness will be provided at the Non-Participating Provider payment levels previously described in this Certificate for Hospital and Physician Covered Services when you receive Covered Services Out-of-Network.

After you have met your program deductible, benefits for the Inpatient treatment of Mental Illness for those illnesses not classified as Serious Mental Illness and Inpatient Substance Abuse Rehabilitation Treatment (in a program that has a written agreement with Blue Cross and Blue Shield) will be provided at [50–100]% of the Eligible Charge or at [50–100]% of the Maximum Allowance when you receive Covered Services Out-of-Network. 22.689

When you receive Out-of-Network Covered Services for the Inpatient treatment of Mental Illness or Substance Abuse Rehabilitation Treatment in a Non-Plan Provider facility, benefits will be provided at 50% of the Eligible Charge after you have met your program deductible.

[You are entitled to a maximum of [45–365] Inpatient Hospital days each benefit period for the Inpatient treatment of Serious Mental Illness.] 22.694

[You are entitled to a maximum of [30–365] Inpatient Hospital days each benefit period for the Inpatient treatment of Mental Illness for those illnesses not classified as Serious Mental Illness and a maximum of [30–365] Inpatient Hospital

days each benefit period for Inpatient Substance Abuse Rehabilitation Treatment.] 22.69

[For every two days of care in a Partial Hospitalization Treatment Program, one day is deducted from your Inpatient Hospital days for the treatment of Mental Illness or Substance Abuse Rehabilitation Treatment.]

[None of the charges for the Inpatient and/or Outpatient treatment of Mental Illness for those illnesses not classified as Serious Mental Illness or Substance Abuse Rehabilitation Treatment will be applied in satisfying your Out-of-Pocket Expense Limit as explained later in this Certificate.]

[Lifetime Maximum for Mental Illness and Substance Abuse Rehabilitation Treatment

[Your benefits for the Inpatient and Outpatient treatment of Mental Illness for those illnesses not classified as Serious Mental Illness and Substance Abuse Rehabilitation Treatment are limited to a combined lifetime maximum of $[20,000–100,000]. However, the maximum amount that will be paid for Out-of-Network Inpatient and Outpatient treatment of Mental Illness for those illnesses not classified as Serious Mental Illness and Substance Abuse Rehabilitation Treatment is a combined lifetime maximum of $[20,000–100,000].] 22.691

[A combined lifetime maximum of [30–365] Inpatient Hospital days will apply to benefits for Inpatient treatment of Mental Illness for those illnesses not classified as Serious Mental Illness and Substance Abuse Rehabilitation Treatment.] 22.692

[A combined lifetime maximum of [30–365] Outpatient visits will apply to benefits for Outpatient treatment of Mental Illness for those illnesses not classified as Serious Mental Illness and Substance Abuse Rehabilitation Treatment.] 22.693 22.68b

MATERNITY SERVICE

Your benefits for Maternity Service are the same as your benefits for any other condition and are available whether you have Individual Coverage or Family Coverage. Benefits will also be provided for Covered Services rendered by a Certified Nurse-Midwife.

Benefits will be paid for Covered Services received in connection with both normal pregnancy and Complications of Pregnancy. As part of your maternity benefits certain services rendered to your newborn infant are also covered, even if you have Individual Coverage. These Covered Services are: a) the routine Inpatient Hospital nursery charges, b) one routine Inpatient examination as long as this examination is rendered by a Physician other than the Physician who delivered the child or administered anesthesia during delivery and c) one Inpatient hearing screening. (If the newborn child needs treatment for an illness or injury, benefits will be available for that care only if you have Family Coverage. You may apply for Family Coverage within 31 days of date of the birth. Your Family Coverage will then be effective from the date of the birth.)

Benefits will be provided for any hospital length of stay in connection with childbirth for the mother or newborn child for no less than 48 hours following a normal vaginal delivery, or no less than 96 hours following a cesarean section. Your Provider will not

be required to obtain authorization from Blue Cross and Blue Shield for prescribing a length of stay less than 48 hours (or 96 hours).

[Your coverage also includes benefits for elective abortions if legal where performed.] 22.41

[INFERTILITY TREATMENT

Benefits will be provided the same as your benefits for any other condition 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 makes 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 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 makes such treatment useless; and

— You have not undergone four completed oocyte retrievals, except that if a live birth followed a completed oocyte retrieval, two more completed oocyte retrievals shall be covered.

Benefits will also be provided for medical expenses of an oocyte or sperm donor for procedures used to retrieve oocytes or sperm and the subsequent procedure 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 that are eligible for coverage 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.

Special Limitations

Benefits will not be provided for the following:

1. 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.
2. Selected termination of an embryo; provided, however, termination will be covered where the mother's life would be in danger if all embryos were carried to full term.
3. Expenses incurred for cryo-preservation or storage of sperm, eggs or embryos, except for those procedures which use a cryo-preserved substance.
4. Non-medical costs of an egg or sperm donor.
5. Travel costs for travel within 100 miles of your home or travel costs not Medically Necessary or required by Blue Cross and Blue Shield.
6. Infertility treatments which are deemed Investigational, in writing, by the American Society for Reproductive Medicine or the American College of Obstetricians or Gynecologists.
7. Infertility treatment rendered to your dependents under age 18.

In addition to the above provisions, in-vitro fertilization, gamete intrafallopian tube transfer, zygote intrafallopian tube transfer, low tubal ovum transfer and intracytoplasmic sperm injection procedures must be performed at medical facilities that conform to the American College of Obstetricians and Gynecologists guidelines for in-vitro fertilization clinics or to the American Society for Reproductive Medicine minimal standards for programs of in-vitro fertilization.]

[TEMPOROMANDIBULAR JOINT DYSFUNCTION AND RELATED DISORDERS

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

[Your benefits for the diagnosis and/or treatment of Temporomandibular Joint Dysfunction and Related Disorders are limited to a lifetime maximum of $[500–100,000].] 22.54a

[However, your benefits for the diagnosis and/or treatment of Temporomandibular Joint Dysfunction and Related Disorders are limited to a benefit period maximum of $500[500–100,000].]] 22.54b 22.54

MASTECTOMY-RELATED SERVICES

Benefits for Covered Services related to mastectomies are the same as for any other condition. Mastectomy-related Covered Services include, but are 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. Inpatient care following a mastectomy for the length of time determined by your 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 48 hours after discharge; and

4. Prostheses and physical complications of all stages of the mastectomy including, but not limited to, lymphedemas.

PAYMENT PROVISIONS

Lifetime Maximum

[The total maximum amount of benefits to which you are entitled under this Participating Provider Option program is $[250,000–10,000,000]. This is an individual maximum. There is no family maximum.] 22.50a

[As you use your benefits, a certain amount will automatically be restored to your lifetime maximum each year. This amount will be $[500–100,000] or the amount you have received in benefits that benefit period, whichever is less.] 22.50a1

[The total dollar amount that will be available in benefits for you is unlimited subject to the separate dollar maximums for specific Covered Services described earlier in this Certificate.] 22.50b

[When Covered Services are received from Participating Provider(s), the total dollar amount that will be available in benefits for you is unlimited subject to the separate dollar maximums for specific Covered Services described earlier in this Certificate.]

[When you receive Covered Services from Non-Participating Provider(s), the total maximum amount of benefits to which you are entitled is $[250,000–10,000,000]. There is no family maximum.[As you use your benefits, a certain amount will automatically be restored to your lifetime maximum each year. This amount will be $[500–100,000] or the amount you have received in benefits for Covered Services received from Non-Participating Providers that benefit period, whichever is less.]] 22.50c 22.50c1

[Cumulative Benefit Maximums

All benefits payable under this Certificate are cumulative. Therefore, in calculating the benefit maximums payable for a particular Covered Service or in calculating the remaining balance under the Lifetime Maximums, Blue Cross and Blue Shield will include benefit payments under both this and/or any prior or subsequent Blue Cross and Blue Shield Certificate issued to you as an Eligible Person or a dependent of an Eligible Person under this Group.] 22.501

[OUT-OF-POCKET EXPENSE LIMIT

[There are separate Out-of-Pocket Expense Limits applicable to Covered Services received from [Community Providers,]Participating Providers and Non-Participating Providers.]

[For Community Providers

If, during one benefit period, your out-of-pocket expense (the amount remaining unpaid after benefits have been provided) equals $[100–20,000][the out-of-pocket expense limit in the Benefit Highlights (an insert) of this Certificate], any additional eligible Claims for Community Providers (except for those Covered Services specifi-

cally excluded below) during that benefit period will be paid at 100% of the Eligible Charge or Maximum Allowance.

This out-of-pocket expense limit may be reached by:

- [the program deductible] 22.518aCPO
- the payments for which you are responsible after benefits have been provided (except for any expenses incurred for Covered Services rendered by a Non-Participating or Non-Plan Provider other than Emergency Accident Care, Emergency Medical Care and Inpatient treatment during the period of time when your condition is serious)
- [charges for Outpatient prescription drugs] 22.513aCPO
- [any expenses incurred for Covered Services during the last 3 months of the prior benefit period which were or could have been applied to that benefit period's out-of-pocket expense limit for Community Providers] 22.519CPO
- [and any unreimbursed expenses incurred for "comprehensive major medical" covered services within your prior contract's benefit period, if not completed.] 22.511CPO 22.51CPO

The following expenses for Covered Services cannot be applied to the out-of-pocket expense limit and will not be paid at 100% of the Eligible Charge or Maximum Allowance when your out-of-pocket expense limit is reached:

- [the program deductible] 22.518bCPO
- [the Inpatient Hospital admission deductible(s)] 22.514aCPO
- charges that exceed the Eligible Charge or Maximum Allowance
- the Coinsurance resulting from Covered Services rendered by a Non-Participating Provider or a Non-Plan Provider
- [charges for Covered Services which have a separate dollar maximum specifically mentioned in this Certificate]
- [charges for Covered Services received for the treatment of Mental Illness for those illnesses not classified as Serious Mental Illness and/or Substance Abuse Rehabilitation Treatment] 22.517CPO
- [charges for Outpatient prescription drugs] 22.513CPO
- [the Hospital emergency room Copayment] 22.515CPO
- [the Copayment for Physician office visits] 22.516aCPO
- Copayments resulting from noncompliance with the provisions of the [Medical Services Advisory Program][Utilization Review Program][and/or the Blue Cross and Blue Shield Mental Health Unit]
- [and any unreimbursed expenses incurred for "comprehensive major medical" covered services within your prior contract's benefit period, if not completed.] 22.512CPO

[If you have Family Coverage and [2,3] members of your family have reached their out-of-pocket expense limit during one benefit period, then, for the rest of the benefit period, all other family members will have benefits for Covered Services received

from a Community Provider (except for those Covered Services specifically excluded above) provided at 100% of the Eligible Charge or Maximum Allowance.]] 22.52CPO

[**For Participating Providers**

[If, during one benefit period, your out-of-pocket expense (the amount remaining unpaid after benefits have been provided) equals $[100–20,000], any additional eligible Claims for [Community Providers and]Participating Providers (except for those Covered Services specifically excluded below) during that benefit period will be paid at 100% of the Eligible Charge or Maximum Allowance.] 22.51PD

[If, during one benefit period, your out-of-pocket expense (the amount remaining unpaid after benefits have been provided) equals the out-of-pocket expense limit in the Benefit Highlights (an insert) of this Certificate, any additional eligible Claims for Participating Providers (except for those Covered Services specifically excluded below) during that benefit period will be paid at 100% of the Eligible Charge or Maximum Allowance.] 22.51PG

This out-of-pocket expense limit may be reached by:

- [the [Participating Provider] program deductible] 22.518a
- the payments for which you are responsible after benefits have been provided (except for any expenses incurred for Covered Services rendered by a Non-Participating or Non-Plan Provider other than Emergency Accident Care, Emergency Medical Care and Inpatient treatment during the period of time when your condition is serious)
- [charges for Outpatient prescription drugs] 22.513a
- [any expenses incurred for Covered Services during the last 3 months of the prior benefit period which were or could have been applied to that benefit period's out-of-pocket expense limit for Participating Providers] 22.520a
- [and any unreimbursed expenses incurred for "comprehensive major medical" covered services within your prior contract's benefit period, if not completed.] 22.511

The following expenses for Covered Services cannot be applied to the out-of-pocket expense limit and will not be paid at 100% of the Eligible Charge or Maximum Allowance when your out-of-pocket expense limit is reached:

- [the program deductible(s)] 22.518b
- [the Inpatient Hospital admission deductible(s)] 22.514a
- charges that exceed the Eligible Charge or Maximum Allowance
- the Coinsurance resulting from Covered Services rendered by a Non-Participating Provider or a Non-Plan Provider
- [charges for Covered Services which have a separate dollar maximum specifically mentioned in this Certificate] 22.519a
- [charges for Covered Services received for the treatment of Mental Illness for those illnesses not classified as Serious Mental Illness and/or Substance Abuse Rehabilitation Treatment] 22.517
- [charges for Outpatient prescription drugs] 22.513

- [the Hospital emergency room Copayment] 22.515
- [the urgent care Copayment] 22.521a
- [the Copayment for Physician office visits] 22.516a
- [the Copayment for specialist's office visits] 22.522a
- Copayments resulting from noncompliance with the provisions of the [Medical Services Advisory Program][Utilization Review Program][and/or the Blue Cross and Blue Shield Mental Health Unit]
- [and any unreimbursed expenses incurred for "comprehensive major medical" covered services within your prior contract's benefit period, if not completed.] 22.512

[If you have Family Coverage and [2,3] members of your family have reached their out-of-pocket expense limit during one benefit period, then, for the rest of the benefit period, all other family members will have benefits for Covered Services (except for those Covered Services specifically excluded above) provided at 100% of the Eligible Charge or Maximum Allowance.] 22.52aPPO

[If you have Family Coverage and your out-of-pocket expense as described above equals $[200–60,000] during one benefit period, then, for the rest of the benefit period, all other family members will have benefits for Covered Services (except for those Covered Services specifically excluded above) provided at 100% of the Eligible Charge or Maximum Allowance. A member may not apply more than the individual out-of-pocket expense limit toward this amount.] 22.52bPPO

[If you have Family Coverage and during one benefit period your out-of-pocket expense as described above equals the Participating Provider family out-of-pocket expense limit in the Benefit Highlights (an insert) of this Certificate, then, for the rest of the benefit period, all other family members will have benefits for Covered Services (except for those Covered Services specifically excluded above) provided at 100% of the Eligible Charge or Maximum Allowance. A member may not apply more than the individual out-of-pocket expense limit toward this amount.]] 22.52bGPPO

[**For Non-Participating Providers**

[If, during one benefit period, your out-of-pocket expense (the amount remaining unpaid after benefits have been provided) equals $[100–20,000], any additional eligible Claims for Non-Participating Providers (except for those Covered Services specifically excluded below) during that benefit period will be paid at 100% of the Eligible Charge or Maximum Allowance.] 22.51NPD

[If, during one benefit period, your out-of-pocket expense (the amount remaining unpaid after benefits have been provided) equals the out-of-pocket expense limit in the Benefit Highlights (an insert) of this Certificate, any additional eligible Claims for Non-Participating Providers (except for those Covered Services specifically excluded below) during that benefit period will be paid at 100% of the Eligible Charge or Maximum Allowance.] 22.51NPG

This out-of-pocket expense limit may be reached by:

- [the[Non-Participating Provider] program deductible] 22.518a1

- the payments for Covered Services rendered by a Non-Participating Provider for which you are responsible after benefits have been provided
- [charges for Outpatient prescription drugs] 22.5131a
- [any expenses incurred for Covered Services during the last 3 months of the prior benefit period which were or could have been applied to that benefit period's out-of-pocket expense limit for Non-Participating Providers] 22.520b

The following expenses for Covered Services cannot be applied to the out-of-pocket expense limit and will not be paid at 100% of the Eligible Charge or Maximum Allowance when your out-of-pocket expense limit is reached:

- [the program deductible(s)] 22.518b1
- [the Inpatient Hospital admission deductible(s)] 22.514b
- charges that exceed the Eligible Charge or Maximum Allowance
- [the Coinsurance resulting from Covered Services you may receive from a Participating Provider] 22.51Pa
- [the Coinsurance resulting from Covered Services you may receive from a Community Provider] 22.51CPO
- the Coinsurance resulting from Covered Services rendered by a Non-Plan Hospital or other Non-Plan Provider facility
- [charges for Covered Services which have a separate dollar maximum specifically mentioned in this Certificate] 22.519b
- [charges for Covered Services received for the treatment of Mental Illness for those illnesses not classified as Serious Mental Illness and/or Substance Abuse Rehabilitation Treatment] 22.5171
- [charges for Outpatient prescription drugs] 22.5131
- [the urgent care Copayment] 22.521b
- [the Hospital emergency room Copayment] 22.5151
- [the Copayment for Physician office visits] 22.516b
- [the Copayment for specialist office visits] 22.522b
- Copayments resulting from noncompliance with the provisions of the [Medical Services Advisory Program][Utilization Review Program][and/or the Blue Cross and Blue Shield Mental Health Unit]
- [any unreimbursed expenses incurred for "comprehensive major medical" covered services within your prior contract's benefit period.] 22.51

[If you have Family Coverage and [2,3] members of your family have reached their out-of-pocket expense limit during one benefit period, then, for the rest of the benefit period, all other family members will have benefits for Covered Services (except for those Covered Services specifically excluded above) provided at 100% of the Eligible Charge or Maximum Allowance.] 22.52aNP

[If you have Family Coverage and your expense as described above equals $[200–60,000] during one benefit period, then, for the rest of the benefit period, all other family members will have benefits for Covered Services (except for those Covered Services specifically excluded above) provided at 100% of the Eligible Charge or Maximum Allowance. A member may not apply more than the individual out-of-pocket expense limit toward this amount.] 22.52bNP

[If you have Family Coverage and during one benefit period your out-of-pocket expense as described above equals the Non-Participating Provider family out-of-pocket expense limit in the Benefit Highlights (an insert) of this Certificate, then, for the rest of the benefit period, all other family members will have benefits for Covered Services (except for those Covered Services specifically excluded above) provided at 100% of the Eligible Charge or Maximum Allowance. A member may not apply more than the individual out-of-pocket expense limit toward this amount.]] 22.52bGNP

[OUT-OF-POCKET EXPENSE LIMIT 22.83 Cross-Feed OPX

[There are separate Out-of-Pocket Expense Limits applicable to Covered Services received from [Community Providers,]Participating Providers and Non-Participating Providers.]

[For Community Providers 22.83CPO

If, during one benefit period, your out-of-pocket expense (the amount remaining unpaid after benefits have been provided) equals $[100–20,000][the out-of-pocket expense limit in the Benefit Highlights (an insert) of this Certificate], any additional eligible Claims for Community Providers (except for those Covered Services specifically excluded below) during that benefit period will be paid at 100% of the Eligible Charge or Maximum Allowance.

This out-of-pocket expense limit may be reached by:

- [the program deductible(s)] 22.838aCPO
- the payments for which you are responsible after benefits have been provided (except for any expenses incurred for Covered Services rendered by a Non-Plan Provider other than Emergency Accident Care, Emergency Medical Care and Inpatient treatment during the period of time when your condition is serious)
- [charges for Outpatient prescription drugs] 22.833aCPO
- [any expenses incurred for Covered Services during the last 3 months of the prior benefit period which were or could have been applied to that benefit period's out-of-pocket expense limit for Community Providers] 22.839CPO
- [and any unreimbursed expenses incurred for "comprehensive major medical" covered services within your prior contract's benefit period, if not completed.] 22.831CPO

The following expenses for Covered Services cannot be applied to the out-of-pocket expense limit and will not be paid at 100% of the Eligible Charge or Maximum Allowance when your out-of-pocket expense limit is reached:

- [the program deductible(s)] 22.838bCPO
- [the Inpatient Hospital admission deductible(s)] 22.834aCPO

- charges that exceed the Eligible Charge or Maximum Allowance
- the Coinsurance resulting from Covered Services rendered by a Non-Plan Hospital or other Non-Plan Provider facility
- [charges for Covered Services which have a separate dollar maximum specifically mentioned in this Certificate] 22.830CPO
- [charges for Covered Services received for the treatment of Mental Illness for those illnesses not classified as Serious Mental Illness and/or Substance Abuse Rehabilitation Treatment] 22.837CPO
- [charges for Outpatient prescription drugs] 22.833CPO
- [the Hospital emergency room Copayment] 22.835CPO
- [the Copayment for Physician office visits] 22.836aCPO
- Copayments resulting from noncompliance with the provisions of the [Medical Services Advisory Program][Utilization Review Program][and/or the Blue Cross and Blue Shield Mental Health Unit]
- [and any unreimbursed expenses incurred for "comprehensive major medical" covered services within your prior contract's benefit period, if not completed.] 22.832CPO

[If you have Family Coverage and [2,3] members of your family have reached their out-of-pocket expense limit during one benefit period, then, for the rest of the benefit period, all other family members will have benefits for Covered Services received from a Community Provider (except for those Covered Services specifically excluded above) provided at 100% of the Eligible Charge or Maximum Allowance.]] 22.52CPO

[**For Participating Providers**

[If, during one benefit period, your out-of-pocket expense (the amount remaining unpaid after benefits have been provided) equals $[100–20,000], any additional eligible Claims for [Community Providers and]Participating Providers (except for those Covered Services specifically excluded below) during that benefit period will be paid at 100% of the Eligible Charge or Maximum Allowance.] 22.83D

[If, during one benefit period, your out-of-pocket expense (the amount remaining unpaid after benefits have been provided) equals the out-of-pocket expense limit in the Benefit Highlights (an insert) of this Certificate, any additional eligible Claims for Participating Providers (except for those Covered Services specifically excluded below) during that benefit period will be paid at 100% of the Eligible Charge or Maximum Allowance.] 22.83G

This out-of-pocket expense limit may be reached by:

- [the[Participating Provider] program deductible[(s)]] 22.838a
- the payments for which you are responsible after benefits have been provided (except for any expenses incurred for Covered Services rendered by a [Non-Participating or]Non-Plan Provider other than Emergency Accident Care, Emergency Medical Care and Inpatient treatment during the period of time when your condition is serious) code for one-way feed
- [charges for Outpatient prescription drugs] 22.833a

- [any expenses incurred for Covered Services during the last 3 months of the prior benefit period which were or could have been applied to that benefit period's out-of-pocket expense limit for Participating Providers] 22.830a
- [and any unreimbursed expenses incurred for "comprehensive major medical" covered services within your prior contract's benefit period, if not completed.] 22.831

The following expenses for Covered Services cannot be applied to the out-of-pocket expense limit and will not be paid at 100% of the Eligible Charge or Maximum Allowance when your out-of-pocket expense limit is reached:

- [the program deductible(s)] 22.838b
- [the Inpatient Hospital admission deductible(s)] 22.834a
- charges that exceed the Eligible Charge or Maximum Allowance
- [the Coinsurance resulting from Covered Services rendered by a Non-Participating Provider] code for one-way feed
- the Coinsurance resulting from Covered Services rendered by a Non-Plan Hospital or other Non-Plan Provider facility
- [charges for Covered Services which have a separate dollar maximum specifically mentioned in this Certificate] 22.839a
- [charges for Covered Services received for the treatment of Mental Illness for those illnesses not classified as Serious Mental Illness and/or Substance Abuse Rehabilitation Treatment] 22.837
- [charges for Outpatient prescription drugs] 22.833
- [the Hospital emergency room Copayment] 22.835
- [the urgent care Copayment] 22.831a
- [the Copayment for Physician office visits] 22.836a
- [the Copayment for specialist's office visits] 22.832a
- Copayments resulting from noncompliance with the provisions of the [Medical Services Advisory Program][Utilization Review Program][and/or the Blue Cross and Blue Shield Mental Health Unit]
- [and any unreimbursed expenses incurred for "comprehensive major medical" covered services within your prior contract's benefit period, if not completed.] 22.832

[If you have Family Coverage and [2,3] members of your family have reached their out-of-pocket expense limit during one benefit period, then, for the rest of the benefit period, all other family members will have benefits for Covered Services (except for those Covered Services specifically excluded above) provided at 100% of the Eligible Charge or Maximum Allowance.] 22.83F1

[If you have Family Coverage and your out-of-pocket expense as described above equals $[200–60,000] during one benefit period, then, for the rest of the benefit period, all other family members will have benefits for Covered Services (except for those Covered Services specifically excluded above) provided at 100% of the Eligible

Charge or Maximum Allowance. A member may not apply more than the individual out-of-pocket expense limit toward this amount.] 22.83F2

[If you have Family Coverage and during one benefit period your out-of-pocket expense as described above equals the Participating Provider family out-of-pocket expense limit in the Benefit Highlights (an insert) of this Certificate, then, for the rest of the benefit period, all other family members will have benefits for Covered Services (except for those Covered Services specifically excluded above) provided at 100% of the Eligible Charge or Maximum Allowance. A member may not apply more than the individual out-of-pocket expense limit toward this amount.]] 22.83F3

[**For Non-Participating Providers**

[If, during one benefit period, your out-of-pocket expense (the amount remaining unpaid after benefits have been provided) equals $[100–20,000], any additional eligible Claims for Non-Participating Providers (except for those Covered Services specifically excluded below) during that benefit period will be paid at 100% of the Eligible Charge or Maximum Allowance.] 22.83D

[If, during one benefit period, your out-of-pocket expense (the amount remaining unpaid after benefits have been provided) equals the out-of-pocket expense limit in the Benefit Highlights (an insert) of this Certificate, any additional eligible Claims for Non-Participating Providers (except for those Covered Services specifically excluded below) during that benefit period will be paid at 100% of the Eligible Charge or Maximum Allowance.] 22.83G

This out-of-pocket expense limit may be reached by:

- [the [Non-Participating Provider]program deductible[(s)]] 22.838a1
- [the payments for Covered Services rendered by a Non-Participating Provider for which you are responsible after benefits have been provided] code for one-way feed
- [the payments for which you are responsible after benefits have been provided (except for any expenses incurred for Covered Services rendered by a Non-Plan Provider other than Emergency Accident Care, Emergency Medical Care and Inpatient treatment during the period of time when your condition is serious)]
- [charges for Outpatient prescription drugs] 22.8331a
- [any expenses incurred for Covered Services during the last 3 months of the prior benefit period which were or could have been applied to that benefit period's out-of-pocket expense limit for Non-Participating Providers] 22.830b

The following expenses for Covered Services cannot be applied to the out-of-pocket expense limit and will not be paid at 100% of the Eligible Charge or Maximum Allowance when your out-of-pocket expense limit is reached:

- [the program deductible(s)] 22.838b1
- [the Inpatient Hospital admission deductible(s)] 22.834b
- charges that exceed the Eligible Charge or Maximum Allowance
- [the Coinsurance resulting from Covered Services rendered by a Participating Provider] code for one-way feed

- the Coinsurance resulting from Covered Services rendered by a Non-Plan Hospital or other Non-Plan Provider facility
- [charges for Covered Services which have a separate dollar maximum specifically mentioned in this Certificate] 22.839b
- [charges for Covered Services received for the treatment of Mental Illness for those illnesses not classified as Serious Mental Illness and/or Substance Abuse Rehabilitation Treatment] 22.8371
- [charges for Outpatient prescription drugs] 22.8331
- [the urgent care Copayment] 22.831b
- [the Hospital emergency room Copayment] 22.8351
- [the Copayment for Physician office visits] 22.836b
- [the Copayment for specialist office visits] 22.832b
- Copayments resulting from noncompliance with the provisions of the [Medical Services Advisory Program][Utilization Review Program][and/or the Blue Cross and Blue Shield Mental Health Unit]
- [any unreimbursed expenses incurred for "comprehensive major medical" covered services within your prior contract's benefit period.] 22.83

[If you have Family Coverage and [2,3] members of your family have reached their out-of-pocket expense limit during one benefit period, then, for the rest of the benefit period, all other family members will have benefits for Covered Services (except for those Covered Services specifically excluded above) provided at 100% of the Eligible Charge or Maximum Allowance.] 22.83F1

[If you have Family Coverage and your expense as described above equals $[200–60,000] during one benefit period, then, for the rest of the benefit period, all other family members will have benefits for Covered Services (except for those Covered Services specifically excluded above) provided at 100% of the Eligible Charge or Maximum Allowance. A member may not apply more than the individual out-of-pocket expense limit toward this amount.] 22.83F2

[If you have Family Coverage and during one benefit period your out-of-pocket expense as described above equals the Non-Participating Provider family out-of-pocket expense limit in the Benefit Highlights (an insert) of this Certificate, then, for the rest of the benefit period, all other family members will have benefits for Covered Services (except for those Covered Services specifically excluded above) provided at 100% of the Eligible Charge or Maximum Allowance. A member may not apply more than the individual out-of-pocket expense limit toward this amount.]] 22.83F3

[OUT-OF-POCKET EXPENSE LIMIT 22.84 Common OPX

[If, during one benefit period, your out-of-pocket expense (the amount remaining unpaid after benefits have been provided) equals $[100–20,000], any additional eligible Claims (except for those charges specifically excluded below) during that benefit period will be paid at 100% of the Eligible Charge or Maximum Allowance.] 22.84D

[If, during one benefit period, your out-of-pocket expense (the amount remaining unpaid after benefits have been provided) equals the out-of-pocket expense limit in the Benefit Highlights (an insert) of this Certificate, any additional eligible Claims (except for those charges specifically excluded below) during that benefit period will be paid at 100% of the Eligible Charge or Maximum Allowance.] 22.84G

This out-of-pocket expense limit may be reached by:

- [the program deductible(s)] 22.848a
- the payments for which you are responsible after benefits have been provided (except for any expenses incurred for Covered Services rendered by a Non-Plan Provider other than Emergency Accident Care, Emergency Medical Care and Inpatient treatment during the period of time when your condition is serious)
- [charges for Outpatient prescription drugs] 22.843a
- [any expenses incurred for Covered Services during the last 3 months of the prior benefit period which were or could have been applied to that benefit period's out-of-pocket expense limit] 22.840a
- [and any unreimbursed expenses incurred for "comprehensive major medical" covered services within your prior contract's benefit period, if not completed.] 22.841

The following expenses for Covered Services cannot be applied to the out-of-pocket expense limit and will not be paid at 100% of the Eligible Charge or Maximum Allowance when your out-of-pocket expense limit is reached:

- [the program deductible(s)] 22.848b
- [the Inpatient Hospital admission deductible(s)] 22.844a
- charges that exceed the Eligible Charge or Maximum Allowance
- the Coinsurance resulting from Covered Services rendered by a Non-Plan Hospital or other Non-Plan Provider facility
- [charges for Covered Services which have a separate dollar maximum specifically mentioned in this Certificate] 22.849a
- [charges for Covered Services received for the treatment of Mental Illness for those illnesses not classified as Serious Mental Illness and/or Substance Abuse Rehabilitation Treatment] 22.847
- [charges for Outpatient prescription drugs] 22.843
- [the Hospital emergency room Copayment] 22.845
- [the urgent care Copayment] 22.841a
- [the Copayment for Physician office visits] 22.846a
- [the Copayment for specialist's office visits] 22.842a
- Copayments resulting from noncompliance with the provisions of the [Medical Services Advisory Program][Utilization Review Program][and/or the Blue Cross and Blue Shield Mental Health Unit]

- [and any unreimbursed expenses incurred for "comprehensive major medical" covered services within your prior contract's benefit period, if not completed.] 22.842

[If you have Family Coverage and [2,3] members of your family have reached their out-of-pocket expense limit during one benefit period, then, for the rest of the benefit period, all other family members will have benefits for Covered Services (except for those Covered Services specifically excluded above) provided at 100% of the Eligible Charge or Maximum Allowance.] 22.8411a

[If you have Family Coverage and your out-of-pocket expense as described above equals $[200–60,000] during one benefit period, then, for the rest of the benefit period, all other family members will have benefits for Covered Services (except for those Covered Services specifically excluded above) provided at 100% of the Eligible Charge or Maximum Allowance. A member may not apply more than the individual out-of-pocket expense limit toward this amount.] 22.8411b

[If you have Family Coverage and during one benefit period your out-of-pocket expense as described above equals the family out-of-pocket expense limit in the Benefit Highlights (an insert) of this Certificate, then, for the rest of the benefit period, all other family members will have benefits for Covered Services (except for those Covered Services specifically excluded above) provided at 100% of the Eligible Charge or Maximum Allowance. A member may not apply more than the individual out-of-pocket expense limit toward this amount.]] 22.8411c

[OUT-OF-POCKET EXPENSE LIMIT

If you have Individual Coverage and your out-of-pocket expense during one benefit period (the amount remaining unpaid for Covered Services after benefits have been provided) equals $[100–20,000], any additional eligible Claims (except for those charges specifically excluded below) during that benefit period will be paid at 100% of the Eligible Charge or Maximum Allowance. 22.71PD

[If you have Individual Coverage and your out-of-pocket expense (the amount remaining unpaid after benefits have been provided) equals the out-of-pocket expense limit in the Benefit Highlights (an insert) of this Certificate, any additional eligible Claims (except for those Covered Services specifically excluded below) during that benefit period will be paid at 100% of the Eligible Charge or Maximum Allowance.] 22.71PG

This out-of-pocket expense limit may be reached by:

- [the program deductible] 22.71a
- [the Inpatient Hospital admission deductible(s)] 22.712
- [the urgent care Copayment] 22.718
- [the emergency room Copayment] 22.713
- [the Copayment for Physician office visits] 22.714
- [the Copayment for specialist office visits] 22.719
- [charges for Outpatient prescription drugs] 22.715
- the payments for Covered Services which you are responsible after benefits have been provided.

The following expenses for Covered Services cannot be applied to the out-of-pocket expense limit and will not be paid at 100% of the Eligible Charge or Maximum Allowance when your out-of-pocket expense limit is reached:

- [the program deductible] 22.71b
- charges that exceed the Eligible Charge or Maximum Allowance
- [charges for Covered Services which have a separate dollar maximum specifically mentioned in this Certificate] 22.716
- [charges for Covered Services received for the treatment of Mental Illness for those illnesses not classified as Serious Mental Illness and/or Substance Abuse Rehabilitation Treatment] 22.717
- Copayments resulting from noncompliance with the provisions of the [Medical Services Advisory Program][Utilization Review Program][and/or the Blue Cross and Blue Shield Mental Health Unit]. 22.71

[If you have Family Coverage and your family's out-of-pocket expense (the amount remaining unpaid for Covered Services after benefits have been provided) equals $[200–60,000] during one benefit period, then, for the rest of the benefit period, all other family members will have benefits for eligible Covered Services (except for those charges specifically excluded above) provided at 100% of the Eligible Charge or Maximum Allowance. Benefits under Family Coverage will not be provided at the 100% payment level until the entire family out-of-pocket expense limit has been met.] 22.52cD

[If you have Family Coverage and during one benefit period your family's out-of-pocket expense as described above equals the Family Coverage out-of-pocket expense limit in the Benefit Highlights (an insert) of this Certificate, then, for the rest of the benefit period, all other family members will have benefits for Covered Services (except for those Covered Services specifically excluded above) provided at 100% of the Eligible Charge or Maximum Allowance. Benefits under Family Coverage will not be provided at the 100% payment level until the entire family out-of-pocket expense limit has been met.] 22.52cG

[**The out-of-pocket expense limit amount may be adjusted based on the cost-of-living adjustment determined under the Internal Revenue Code and rounded to the nearest $50.**]] 22.71

[**OUT-OF-POCKET EXPENSE LIMIT**

[There are separate Out-of-Pocket Expense Limits applicable to Covered Services received from Participating Providers and Non-Participating Providers.] 22.81

[**For Participating Providers**

[If you have Individual Coverage and your out-of-pocket expense (the amount remaining unpaid for Covered Services after benefits have been provided) during one benefit period equals $[100–20,000], any additional eligible Claims for Participating Providers (except for those charges specifically excluded below) during that benefit period will be paid at 100% of the Eligible Charge or Maximum Allowance.] 22.81PD

[If you have Individual Coverage and your out-of-pocket expense (the amount remaining unpaid for Covered Services after benefits have been provided) during one benefit period equals the Individual Coverage out-of-pocket expense limit in the Benefit Highlights (an insert) of this Certificate, any additional eligible Claims for Participating Providers (except for those Covered Services specifically excluded below) during that benefit period will be paid at 100% of the Eligible Charge or Maximum Allowance.] 22.81PG

This out-of-pocket expense limit may be reached by:

- [the [Participating Provider] program deductible] 22.818a
- [the Inpatient Hospital admission deductible(s)] 22.814a
- [the urgent care Copayment] 22.821a
- [the emergency room Copayment] 22.815
- [the Copayment for Physician office visits] 22.816a
- [the Copayment for specialist's office visits] 22.822a
- [charges for Outpatient prescription drugs] 22.815a
- the payments for Covered Services for which you are responsible after benefits have been provided (except for any expenses incurred for Covered Services rendered by a Non-Participating or Non-Plan Provider other than Emergency Accident Care, Emergency Medical Care and Inpatient treatment during the period of time when your condition is serious)

The following expenses for Covered Services cannot be applied to the out-of-pocket expense limit and will not be paid at 100% of the Eligible Charge or Maximum Allowance when your out-of-pocket expense limit is reached:

- [the program deductible(s)] 22.818b
- charges that exceed the Eligible Charge or Maximum Allowance
- the Coinsurance resulting from Covered Services rendered by a [Non-Participating Provider or]Non-Plan Provider
- [charges for Covered Services which have a separate dollar maximum specifically mentioned in this Certificate] 22.819a
- [charges for Covered Services received for the treatment of Mental Illness for those illnesses not classified as Serious Mental Illness and/or Substance Abuse Rehabilitation Treatment] 22.820a
- Copayments resulting from noncompliance with the provisions of the [Medical Services Advisory Program][Utilization Review Program][and/or the Blue Cross and Blue Shield Mental Health Unit]

[If you have Family Coverage and your family's out-of-pocket expense (the amount remaining unpaid for Covered Services after benefits have been provided) equals $[200–60,000] during one benefit period, then, for the rest of the benefit period, all other family members will have benefits for eligible Covered Services (except for those charges specifically excluded above) provided at 100% of the Eligible Charge or Maximum Allowance. Benefits under Family Coverage will not be provided at the

100% payment level until the entire family out-of-pocket expense limit has been met.] 22.52dD

[If you have Family Coverage and during one benefit period your family's out-of-pocket expense as described above equals the Family Coverage out-of-pocket expense limit in the Benefit Highlights (an insert) of this Certificate, then, for the rest of the benefit period, all other family members will have benefits for Covered Services (except for those Covered Services specifically excluded above) provided at 100% of the Eligible Charge or Maximum Allowance. Benefits under Family Coverage will not be provided at the 100% payment level until the entire family out-of-pocket expense limit has been met.]] 22.52dG

[For Non-Participating Providers

[If you have Individual Coverage and your out-of-pocket expense (the amount remaining unpaid for Covered Services after benefits have been provided) during one benefit period equals $[100–20,000], any additional eligible Claims for Non-Participating Providers (except for those Covered Services specifically excluded below) during that benefit period will be paid at 100% of the Eligible Charge or Maximum Allowance.] 22.81NPD

[If you have Individual Coverage and your out-of-pocket expense (the amount remaining unpaid for Covered Services after benefits have been provided) during one benefit period equals the Individual Coverage out-of-pocket expense limit in the Benefit Highlights (an insert) of this Certificate, any additional eligible Claims for Non-Participating Providers (except for those Covered Services specifically excluded below) during that benefit period will be paid at 100% of the Eligible Charge or Maximum Allowance.] 22.81NPG

This out-of-pocket expense limit may be reached by:

- [the [Non-Participating Provider]program deductible] 22.818a1
- [the Inpatient Hospital admission deductible(s)] 22.814b
- [the urgent care Copayment] 22.821b
- [the emergency room Copayment] 22.8151
- [the Copayment for Physician office visits] 22.816b
- [the Copayment for specialist office visits] 22.822b
- [charges for Outpatient prescription drugs] 22.815b
- the payments for Covered Services rendered by a Non-Participating Provider for which you are responsible after benefits have been provided

The following expenses for Covered Services cannot be applied to the out-of-pocket expense limit and will not be paid at 100% of the Eligible Charge or Maximum Allowance when your out-of-pocket expense limit is reached:

- [the program deductible(s)] 22.818b1
- charges that exceed the Eligible Charge or Maximum Allowance
- [the Coinsurance resulting from Covered Services you may receive from a Participating Provider]

- the Coinsurance resulting from Hospital services rendered by a Non-Plan Hospital or other Non-Plan Provider facility for Covered Services
- [charges for Covered Services which have a separate dollar maximum specifically mentioned in this Certificate] 22.819b
- [charges for Covered Services received for the treatment of Mental Illness for those illnesses not classified as Serious Mental Illness and/or Substance Abuse Rehabilitation Treatment] 22.820b
- Copayments resulting from noncompliance with the provisions of the [Medical Services Advisory Program][Utilization Review Program][and/or the Blue Cross and Blue Shield Mental Health Unit] **Revised**

[If you have Family Coverage and your family's out-of-pocket expense (the amount remaining unpaid for Covered Services after benefits have been provided) equals $[200–60,000] during one benefit period, then, for the rest of the benefit period, all other family members will have benefits for eligible Covered Services (except for those charges specifically excluded above) provided at 100% of the Eligible Charge or Maximum Allowance. Benefits under Family Coverage will not be provided at the 100% payment level until the entire family out-of-pocket expense limit has been met.] 22.52dD

[If you have Family Coverage and during one benefit period your family's out-of-pocket expense as described above equals the Family Coverage out-of-pocket expense limit in the Benefit Highlights (an insert) of this Certificate, then, for the rest of the benefit period, all other family members will have benefits for Covered Services (except for those Covered Services specifically excluded above) provided at 100% of the Eligible Charge or Maximum Allowance. Benefits under Family Coverage will not be provided at the 100% payment level until the entire family out-of-pocket expense limit has been met.] 22.52dG

[**The out-of-pocket expense limit amount may be adjusted based on the cost-of-living adjustment determined under the Internal Revenue Code and rounded to the nearest $50.**]] 22.81

EXTENSION OF BENEFITS IN CASE OF TERMINATION

If you are an Inpatient at the time your coverage under this Certificate is terminated, benefits will be provided for, and limited to, the Covered Services of this Certificate which are rendered by and regularly charged for by a Hospital, Skilled Nursing Facility, [Substance Abuse Treatment Facility,][Partial Hospitalization Treatment Program]or Coordinated Home Care Program. Benefits will be provided until you are discharged or until the end of your benefit period, whichever occurs first.

THE PARTICIPATING PROVIDER OPTION

Your employer has chosen Blue Cross and Blue Shield's ''Participating Provider Option'' for the administration of your Hospital benefits. The Participating Provider Option is a program of health care benefits designed to provide you with economic incentives for using designated Providers of health care services.

As a participant in the Participating Provider Option a directory of Participating Hospitals is available to you. You can visit the Blue Cross and Blue Shield of Illinois Web site at *www.bcbsil.com* for a list of Participating Hospitals. While there may be changes in the directory from time to time, selection of Participating Hospitals by Blue Cross and Blue Shield will continue to be based upon the range of services, geographic location and cost-effectiveness of care. Notice of changes in the network will be provided to your Group Administrator annually, or as required, to allow you to make selection within the Hospital network. However, you are urged to check with your Hospital before undergoing treatment to make certain of its participation status. Although you can go to the Hospital of your choice, Hospital benefits under the Participating Provider Option will be greater when you use the services of a Participating Hospital.

Before reading the description of your benefits, you should understand the terms "Benefit Period" and "Deductible" as defined below.

YOUR BENEFIT PERIOD

Your benefit period is a period of one year which begins on [Month Day] of each year. When you first enroll under this coverage, your first benefit period begins on your Coverage Date, and ends on the first [Month Day] following that date. 20.20

[YOUR DEDUCTIBLE

[Each benefit period you must satisfy a $[100–20,000] deductible. In other words, after you have claims for more than $[100–20,000] of Covered Services in a benefit period, your benefits will begin. This deductible will be referred to as the program deductible.] 20.01a

[Each benefit period you must satisfy a [$[100–20,000] deductible for Covered Services rendered by Participating Hospital(s), Plan Provider facility and Physician(s) and a separate $[200–60,000] deductible for Covered Services rendered by Non-Participating Hospital(s) or Non-Plan Provider(s)][the deductible amount(s) specified in the Benefit Highlights (an insert) of this Certificate]. In other words, after you have Claims for Covered Services for more than the deductible amount in a benefit period, your benefits will begin. This deductible will be referred to as the program deductible.] 20.01b 20.01b1 20.01b2

[In addition to your program deductible, each time you are admitted to a Participating Hospital, you must satisfy a $[100–5,000] deductible.] 20.0112

[Each time you are admitted to a Non-Participating Hospital or Non-Plan Hospital, you must satisfy a $[100–5,000] deductible. This deductible is in addition to your program deductible.] 20.0113

[If you have any Covered Services expenses during the last three months of a benefit period which were or could have been applied to that benefit period's program deductible, these expenses may be applied toward the program deductible of the next benefit period.] 20.04

[If you have Family Coverage and [2,3] members of your family have each satisfied their program deductible, it will not be necessary for anyone else in your family to meet a program deductible in that benefit period. That is, for the remainder of that benefit period, no other family members are required to meet the program deductible before receiving benefits.] 20.02a

[If you have Family Coverage and your family has reached the program deductible amount of $[100–20,000], it will not be necessary for anyone else in your family to meet a program deductible in that benefit period. That is, for the remainder of that benefit period, no other family members are required to meet a program deductible before receiving benefits. A family member may not apply more than the individual program deductible amount toward the family program deductible.] 20.02b

[In any case, should two or more members of your family ever receive Covered Services as a result of injuries received in the same accident, only one such program deductible will be applied against those Covered Services.] 20.05

[When your group initially purchased this coverage, if you were a member of the Group at that time you are entitled to a special credit toward your [Participating Hospital]program deductible for the first benefit period. This special credit applies to eligible expenses incurred for Covered Services within the prior contract's benefit period, if not completed. Such expenses can be applied toward the [Participating Hospital]program deductible for the first benefit period under this coverage. However, this is only true if your Group had "major medical" type coverage immediately prior to purchasing this coverage.]] 20.03

HOSPITAL BENEFIT SECTION

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

The benefits of this section are subject to all of the terms and conditions of this Certificate. [Your benefits are also subject to the Preexisting Condition waiting period.]Please refer to the DEFINITIONS, ELIGIBILITY and EXCLUSIONS sections of this Certificate for additional information regarding any limitations and/or special conditions pertaining to your benefits. 0.564

In addition, the benefits described in this section will be provided only when you receive services on or after your Coverage Date and they are rendered upon the direction or under the direct care of your Physician. Such services must be Medically Necessary and regularly included in the Provider's charges.

[The level of benefits paid for Hospital Covered Services is generally greater when received in a Plan Hospital or other Plan facility.] 20.10

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

INPATIENT CARE

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

Inpatient Covered Services

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

Preadmission Testing

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

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

Partial Hospitalization Treatment Program

[You must be admitted to this program within 72 hours of discharge from a covered Inpatient Hospital admission.]Benefits are available for this program only if it is a Blue Cross and Blue Shield approved program. No benefits will be provided for services received in a Partial Hospitalization Treatment Program which has not been approved by Blue Cross and Blue Shield. 20.54

[Benefits for Covered Services received in a Partial Hospitalization Treatment Program will be provided at the payment level specified for Inpatient treatment of Mental Illness and Inpatient Substance Abuse Rehabilitation Treatment in the SPECIAL CONDITIONS AND PAYMENT section of this Certificate.] 20.55b

Coordinated Home Care Program

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

[Each time you are admitted to a Coordinated Home Care Program, you are entitled to benefits for [5–365] visits.] 20.60a

[You are entitled to benefits for [5–365] visits in a Coordinated Home Care Program per benefit period.] 20.60b

BENEFIT PAYMENT FOR INPATIENT HOSPITAL COVERED SERVICES

Participating Hospital

When you receive Inpatient Covered Services in a Participating Hospital or in a Plan Program of a Participating Hospital, benefits will be provided at [50–100]% of the Hospital's Eligible Charge[after you have met your program deductible][and your Inpatient Hospital admission deductible], unless otherwise specified in this Certificate.[Your program deductible will not apply.] If you are in a private room, benefits will be limited by the Hospital's rate for its most common type of room with two or more beds. 20.11 20.1111a

[Benefits for preadmission testing by a Participating Hospital will be provided at [50–100]% of the Eligible Charge[after you have met your program deductible].[Benefits for preadmission testing will not be subject to the program deductible.]] 20.11a 20.11a1 20.11a2

[Benefits for services under a Plan Coordinated Home Care Program of a Participating Hospital will be provided at [50–100]% of the Eligible Charge[after you have met your program deductible].[Benefits for services under a Plan Coordinated Home Care Program will not be subject to the program deductible.]] 20.11b 20.11b1 20.11b2

Non-Participating Hospital

When you receive Inpatient Covered Services in a Non-Participating Hospital or in a Plan Program of a Non-Participating Hospital, benefits will be provided at [50–100]% of the Hospital's Eligible Charge[, after you have met your deductible][and your Inpatient Hospital admission deductible], unless otherwise specified in this Certificate. If you are in a private room, benefits will be limited by the Hospital's rate for its most common type of room with two or more beds. 20.12

[Benefits for preadmission testing by a Non-Participating Hospital will be provided at [50–100]% of the Eligible Charge[after you have met your program deductible].[Benefits for preadmission testing will not be subject to the program deductible.]] 20.12a 20.12a1 20.12a2

[Benefits for services under a Plan Coordinated Home Care Program of a Non-Participating Hospital will be provided at [50–100]% of the Eligible Charge[after you have met your program deductible].[Benefits for services under a Plan Coordinated Home Care Program will not be subject to the program deductible.]] 20.12b 20.12b1 22.12b2

Non-Plan Hospital/Facility

[When you receive Inpatient Covered Services in a Non-Plan Hospital, benefits will be provided at 50% of the Eligible Charge[after you have met your program deductible][and your Inpatient Hospital admission deductible]. 20.0113

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

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

In order for you to continue to receive benefits at the Participating Hospital payment level following an emergency admission to a Non-Plan or Non-Participating Hospital, you must transfer to a Participating Hospital or other Participating Provider as soon as your condition is no longer serious.] 20.111a

[When you receive Inpatient Covered Services in a Non-Plan Hospital, benefits will be provided at the same payment level which would have been paid had such services been received from a Non-Participating Hospital.] 20.111b

OUTPATIENT HOSPITAL COVERED SERVICES

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

Outpatient Hospital Covered Services

1. Surgery and any related Diagnostic Service received on the same day as the Surgery
2. Radiation Therapy Treatments
3. Chemotherapy
4. Electroconvulsive Therapy
5. Renal Dialysis Treatments—if received in a Hospital, a Dialysis Facility or in your home under the supervision of a Hospital or Dialysis Facility
6. Diagnostic Service—when you are an Outpatient and these services are related to Surgery or Medical Care
7. Emergency Accident Care—treatment must occur within 72 hours of the accident or as soon as reasonably possible.
8. Emergency Medical Care
9. Mammograms[—Benefits for routine mammograms will be provided at the benefit payment level described in the SPECIAL CONDITIONS AND PAYMENTS section of this Certificate. Benefits for mammograms, other than routine, will be provided at the same payment level as Outpatient Diagnostic Service.] 20.0 **Revised**

10. Pap Smear Test—Benefits will be provided for an annual routine cervical smear or Pap smear test for females[at the benefit payment level described in the Wellness Care provision of this Certificate]. 20.57

11. Prostate Test and Digital Rectal Examination—Benefits will be provided for an annual routine prostate-specific antigen test and digital rectal examination for males[at the benefit payment level described in the Wellness Care provision of this Certificate]. 20.57

12. Ovarian Cancer Screening—Benefits will be provided for annual ovarian cancer screening for females using CA-125 serum tumor marker testing, transvaginal ultrasound, and pelvic examination[at the benefit payment level described in the Wellness Care provision of this Certificate]. 20.57

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

    [Benefits for colorectal cancer screening will be provided at the benefit payment level described in the Wellness Care provision of this Certificate. Benefits for surgical procedures, such as colonoscopy and sigmoidoscopy, are not provided at the Wellness Care payment level. Such procedures will be provided at the benefit payment level for Surgery described in this Certificate.] 20.57

    [Benefits for colorectal cancer screening, including routine colonoscopy and sigmoidoscopy, will be provided at the benefit payment level described in the Wellness Care provision of this Certificate.] **New 9/09**

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

BENEFIT PAYMENT FOR OUTPATIENT HOSPITAL COVERED SERVICES

Participating Hospital/Facility

Benefits will be provided at [50–100]% of the Hospital's Eligible Charge [after you have met your program deductible]when you receive Outpatient Hospital Covered Services in a Participating Hospital or a Plan Dialysis Facility, unless otherwise specified in this Certificate.[Your program deductible will not apply.] 20.14

[Benefits for Outpatient Surgery will be provided at [50–100]% of the Hospital's Eligible Charge in a Participating Hospital[whether you have met your program deductible][after you have met your program deductible].] 20.16 20.16a 20.16b

[Benefits for Outpatient Diagnostic Service and mammograms (other than routine mammograms) will be provided at [50–100]% of the Hospital's Eligible Charge in a Participating Hospital[whether or not you have met your program deductible][after you have met your program deductible]. Routine mammograms will be provided at the payment level described in the SPECIAL CONDITIONS AND PAYMENTS section of this Certificate.] **Revised** 20.19 20.19a 20.19b

Non-Participating Hospital

Benefits will be provided at [50–100]% of the Hospital's Eligible Charge[after you have met your program deductible] when you receive Outpatient Hospital Covered Services in a Non-Participating Hospital, unless otherwise specified in this Certificate.[Your program deductible will not apply.] 20.15

[Benefits for Outpatient Surgery will be provided at [50–100]% of the Hospital's Eligible Charge in a Non-Participating Hospital[whether you have met your program deductible][after you have met your program deductible].] 20.16 20.16a 20.16b

[Benefits for Outpatient Diagnostic Service and mammograms (other than routine mammograms) will be provided at [50–100]% of the Hospital's Eligible Charge in a Non-Participating Hospital[whether or not you have met your program deductible][after you have met your program deductible].] Benefits for routine mammograms will be provided at the benefit payment level described in the SPECIAL CONDITIONS AND PAYMENTS section of this Certificate. 20.19 20.19a 20.19b **Revised**

Non-Plan Hospital/Facility

[When you receive Outpatient Hospital Covered Services from a Non-Plan Hospital or other Non-Plan Provider facility, payment will be 50% of the Eligible Charge[after you have met your program deductible]. Covered Services received for Emergency Accident Care and Emergency Medical Care from a Non-Plan Hospital or other Non-Plan Provider will be paid at the same payment level which would have been paid had such services been received from a Participating Hospital or other Participating Provider.] 20.141a

[When you receive Outpatient Hospital Covered Services in a Non-Plan Hospital, benefits will be provided at the same payment level which would have been paid had such services been received from a Non-Participating Hospital.] 20.141b

Emergency Care

[Benefits for Emergency Accident Care or Emergency Medical Care will be provided at [50–100]% of the Hospital's Eligible Charge in either a Participating, Non-Participating or Non-Plan Hospital whether you have met your program deductible.] 20.17a

[Benefits for Emergency Accident Care or Emergency Medical Care will be provided at [50–100]% of the Hospital's Eligible Charge in either a Participating, Non-Participating or Non-Plan Hospital after you have met your program deductible.] 20.17b

[When you receive Covered Services for Emergency Medical Care from either a Participating, Non-Participating or Non-Plan Hospital, benefits will be provided at [50–100]% of the Eligible Charge [whether you have met your program deductible][after you have met your program deductible]. 20.17c 20.172a 20.172b

[Each time you receive Covered Services in an emergency room, you will be responsible for [a Copayment of $[5–100]][the emergency room Copayment specified in the Benefit Highlights (an insert) of this Certificate]. If you are admitted to the Hospital as as Inpatient immediately following emergency treatment, the emergency room Copayment will be waived.] 20.171 20.171a 20.171b

[However, Covered Services received for Emergency Accident Care and Emergency Medical Care resulting from criminal sexual assault or abuse will be paid at 100% of the Eligible Charge and will not be subject to the program deductible[nor the emergency room Copayment]. 20.18a 20.18a1

[However, Emergency Medical Care Covered Services for the examination and testing of a victim of criminal sexual assault or abuse to determine whether sexual contact occurred, and to establish the presence or absence of sexually transmitted disease or infection, will be paid at 100% of the Eligible Charge whether or not you have met your program deductible.][The emergency room Copayment will not apply.] 20.18b 22.18b1

WHEN SERVICES ARE NOT AVAILABLE IN A PARTICIPATING HOSPITAL

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

PHYSICIAN BENEFIT SECTION

This section of your Certificate tells you what services are covered and how much will be paid when you receive care from a Physician or other specified Provider.

The benefits of this section are subject to all of the terms and conditions of this Certificate. [Your benefits are also subject to the Preexisting Condition waiting period.]Please refer to the DEFINITIONS, ELIGIBILITY and EXCLUSIONS sections of this Certificate for additional information regarding any limitations and/or special conditions pertaining to your benefits. 0.564

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

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

COVERED SERVICES

Surgery

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

1. [surgical removal of complete bony impacted teeth; 20.29a
2. excision of tumors or cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth;][
1. excision of tumors or cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth; 20.29b
2.]surgical procedures to correct accidental injuries of the jaws, cheeks, lips, tongue, roof and floor of the mouth;
3. excision of exostoses of the jaws and hard palate (provided that this procedure is not done in preparation for dentures or other prostheses); treatment of fractures of facial bone; external incision and drainage of cellulitis; incision of accessory sinuses, salivary glands or ducts; reduction of dislocation of, or excision of, the temporomandibular joints.

The following services are also part of your surgical benefits:

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

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

2. Assist at Surgery—when performed by a Physician, Dentist or Podiatrist who assists the operating surgeon in performing covered Surgery in a Hospital or Ambulatory Surgical Facility. In addition, benefits will be provided for assist at Surgery when performed by a Registered Surgical Assistant or an Advanced Practice Nurse. Benefits will also be provided for assist at Surgery performed by a Physician Assistant under the direct supervision of a Physician, Dentist or Podiatrist.[
3. Sterilization Procedures[(even if they are elective).]] 20.27

[**Additional Surgical Opinion**

Your coverage includes benefits for an additional surgical opinion following a recommendation for elective Surgery. Your benefits will be limited to one consultation and related Diagnostic Service by a Physician.[Benefits for an additional surgical opinion consultation and related Diagnostic Service will be provided at 100% of the Usual and Customary Fee[, after you have met your program deductible].[Your program deductible will not apply to this benefit.]]If you request, benefits will be provided for an additional consultation when the need for Surgery, in your opinion, is not resolved by the first arranged consultation.] 20.271 20.271a 20.271b

Medical Care

Benefits are available for Medical Care visits when:

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

[No benefits are available under this Benefit Section for the treatment of Mental Illness for those illnesses not classified as Serious Mental Illness or Outpatient Substance Abuse Rehabilitation Treatment. In addition, the treatment of Mental Illness and Substance Abuse Rehabilitation Treatment are subject to the maximums specified in the SPECIAL CONDITIONS AND PAYMENTS section of this Certificate.] 20.55a

[Your benefits for the Inpatient and Outpatient treatment of Mental Illness and Substance Abuse Rehabilitation Treatment will be provided as described in the SPECIAL CONDITIONS AND PAYMENTS section of this Certificate. However, benefits for the Inpatient treatment of Substance Abuse (i.e. detoxification and/or treatment of medical complications of Substance Abuse) will be provided as specified in the Benefit Payment for Physician Services provision of this Benefit Section.] 20.55b

Consultations

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

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.

[**Well Child Care**

Benefits will be provided for Covered Services provided by a Physician to children under age [one–21], even though they are not ill. Benefits will be limited to the following services:

1. immunizations[for children under age [one–21]]; 20.222
2. physical examinations;
3. routine diagnostic tests. 20.22

[Benefits for well child care will be limited to a maximum of $[100–5,000] per benefit period.]] 20.221

[Benefits for well child care will be limited to a maximum of $[100–5,000] per benefit period. Benefits for the human papillomavirus vaccine are not subject to the well child care benefit maximum.] 20.221 **Revised**

[**Nutritional Counseling**—Benefits will be provided for nutritional counseling[, limited to a maximum of [$[100–5,000]][[one–18] visits] per benefit period].] **New**

Electroconvulsive Therapy

Clinical Breast Examinations—Benefits will be provided for clinical breast examinations when performed by a Physician, Advanced Practice Nurse or a Physician Assistant working under the direct supervision of a Physician.[Benefits for clinical breast examination will be provided at the benefit payment level described in the Wellness Care provision of this Certificate.] **New**

Radiation Therapy Treatments

Chemotherapy

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

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

Pap Smear Test—Benefits will be provided for an annual routine cervical smear or Pap smear test for females[at the benefit payment level described in the Wellness Care provision of this Certificate]. 20.57

Human Papillomavirus Vaccine—Benefits will be provided for a human papillomavirus (HPV) vaccine approved by the federal Food and Drug Administration.[Benefits will be provided at the benefit payment level for **New**

immunizations described in the Well Child Care provision of this Certificate for children under age [one–21].][Benefits will be provided at the benefit payment level for immunizations described in the Wellness Care provision of this Certificate[for persons age [one–21] and over].][Benefits will be provided at the benefit payment level for immunizations described in either the Wellness Care provision or the Well Child Care provision of this Certificate, whichever applies to you.] If you purchase the vaccine at a Pharmacy, benefits will be provided at the Benefit Payment for Other Covered Services described in the OTHER COVERED SERVICES section of this Certificate. [Benefits for the human papillomavirus vaccine are not subject to the well child care benefit maximum.]

20.HPVa

20.HPVb

20.HPVc

Shingles Vaccine—Benefits will be provided for a shingles vaccine approved by the federal Food and Drug Administration[at the benefit payment level described in the Wellness Care provision of this Certificate].

New

Prostate Test and Digital Rectal Examination—Benefits will be provided for an annual routine prostate-specific antigen test and digital rectal examination for males[at the benefit payment level described in the Wellness Care provision of this Certificate].

20.57

Ovarian Cancer Screening—Benefits will be provided for annual ovarian cancer screening for females using CA-125 serum tumor marker testing, transvaginal ultrasound, and pelvic examination[at the benefit payment level described in the Wellness Care provision of this Certificate].

20.57

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

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

20.57

[Benefits for colorectal cancer screening, including routine colonoscopy and sigmoidoscopy, will be provided at the benefit payment level described in the Wellness Care provision of this Certificate.]

New 9/09

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

Emergency Accident Care—Treatment must occur within 72 hours of the accident or as soon as reasonably possible.

Emergency Medical Care

[**Orthotic Devices**—Benefits will be provided for a supportive device for the body or a part of the body, head, neck or extremities, including but not limited to, leg,

back, arm and neck braces. In addition, benefits will be provided for adjustments, repairs or replacement of the device because of a change in your physical condition, as Medically Necessary. However, benefits will not be provided for foot orthotics defined as any in-shoe device designed to support the structural components of the foot during weight-bearing activities.]

New

[**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.]

[No benefits will be provided for [abortions][or surgical sterilization procedures].] 20.28 20.281 20.282

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

New

[**Routine Vision Examination**—Benefits will be provided for [one, 2] routine vision examination[(s)][, limited to a maximum of [$[30–600]][per benefit period].]

New

BENEFIT PAYMENT FOR PHYSICIAN SERVICES

[When you receive any of the Covered Services described in this Physician Benefit Section, [50–100]% of the Usual and Customary Fee will be paid[after you have met your program deductible], unless otherwise specified in this Certificate.[Your program deductible will not apply.]] 20.21

[When you receive Covered Services in your Physician's office, benefits for office visits are subject to a Copayment of $[5–100] per visit.] 20.211

[Your benefits for the treatment of Mental Illness for those illnesses not classified as Serious Mental Illness or Outpatient Substance Abuse Rehabilitation Treatment will be provided as described in the SPECIAL CONDITIONS AND PAYMENTS section of this Certificate. In addition, the treatment of Mental Illness and Substance Abuse Rehabilitation Treatment are subject to the maximums specified in the SPECIAL CONDITIONS AND PAYMENTS section.] 20.55a

[Your benefits for the Inpatient and Outpatient treatment of Mental Illness and Substance Abuse Rehabilitation Treatment will be provided as described in the SPECIAL CONDITIONS AND PAYMENTS section of this Certificate.] 20.55b

[Benefits for well child care will be provided at [50–100]% of the Usual and Customary[whether you have met your program deductible][after you have met your program deductible]. 20.223a 20.223b 20.223

[Benefits for Outpatient Surgery will be provided at [50–100]% of the Usual and Customary Fee.[Your program deductible will [not]apply to these Covered Services.]] 20.25 20.251

[Benefits for Outpatient Diagnostic Service and mammograms (other than routine mammograms) will be provided at [50–100]% of the [Usual and Customary Fee].[Your program deductible will [not] apply to these Covered Services.] Benefits for routine mammograms will be provided at the benefit payment level described in the SPECIAL CONDITIONS AND PAYMENTS section of this Certificate.]	**Revised** 20.26	20.261
[Benefits for routine vision examinations will be provided at [50–100]% of the [Usual and Customary Fee][after you have met your program deductible].][Your program deductible will not apply.]	**New**	
[**Emergency Care**		
[Benefits for Emergency Accident Care and Emergency Medical Care will be provided at [50–100]% of the Usual and Customary Fee.[Your program deductible will [not]apply to these Covered Services.]]	20.23a	20.231a
[Benefits for Emergency Medical Care will be provided at [50–100]% of the Usual and Customary Fee.[Your program deductible will [not]apply to these Covered Services.]]	20.23b	20.231b
[However, Covered Services received for Emergency Accident Care and Emergency Medical Care resulting from criminal sexual assault or abuse will be paid at 100% of the Usual and Customary Fee[whether or not you have met your program deductible].]	20.24a	
[However, Emergency Medical Care Covered Services for the examination and testing of a victim of criminal sexual assault or abuse to determine whether sexual contact occurred, and to establish the presence or absence of sexually transmitted disease or infection, will be paid at 100% of the Usual and Customary Fee[whether or not you have met your program deductible].[The office Copayment will not apply.]]	22.24b	20.24b1

OTHER COVERED SERVICES

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

- Blood and blood components
- Leg, back, arm and neck braces — no longer used
- Physical Therapy—Benefits will be provided for Physical Therapy when rendered by a Physician or by a registered professional physical therapist under the supervision of a Physician. The therapy must be furnished under a written plan established by a Physician and regularly reviewed by the therapist and the Physician. The plan must be established before treatment is begun and must relate to the type, amount, frequency and duration of therapy and indicate the diagnosis and anticipated goals. Benefits for Outpatient Physical Therapy will be limited to a maximum of $[100–20,000] per benefit period.[Your benefits for Occupational Therapy, Physical Therapy and Speech Therapy are limited to a combined maximum of [[20–365] visits][$[1,000–60,000]]per benefit period.] — **New 9/09**
- Private Duty Nursing Service—Benefits for Private Duty Nursing Service will be provided to you in your home only when the services are of such a nature that they cannot be provided by non-professional personnel and can only be provided by a licensed health care provider. No benefits will be provided when a nurse ordinarily resides in your home or is a member of your immediate family. Private Duty Nursing includes teaching and monitoring of complex care skills such as tracheotomy suctioning, medical equipment use and monitoring to home caregivers and is not intended to provide for long term supportive care. Benefits for Private Duty Nursing Service will not be provided due to the lack of willing or available non-professional personnel.[Your benefits for Private Duty Nursing Service are limited to a maximum of $[500–100,000] per [month][benefit period].] — 20.36 20.36a 20.36b
- Ambulance Transportation—Benefits will not be provided for long distance trips or for use of an ambulance because it is more convenient than other transportation.
- Dental accident care—Dental services rendered by a Dentist or Physician which are required as the result of an accidental injury.
- Allergy injections and allergy testing
- Oxygen and its administration
- Medical and surgical dressings, supplies, casts and splints
- Durable medical equipment—Benefits will be provided for such things as internal cardiac valves, internal pacemakers, mandibular reconstruction devices (not used primarily to support dental prosthesis), bone screws, bolts, nails, plates, and any other internal and permanent devices as reasonably approved by Blue Cross and Blue Shield. Benefits will also be provided for the rental (but not to exceed the total cost of equipment) or purchase of durable medical equipment required for temporary therapeutic use provided that this equipment is primarily and customarily used to serve a medical purpose.

- Prosthetic appliances—Benefits will be provided for prosthetic devices, special appliances and surgical implants when:

  a. they are required to replace all or part of an organ or tissue of the human body, or

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

  Benefits will also include adjustments, repair and replacements of covered prosthetic devices, special appliances and surgical implants when required because of wear or change in a patient's condition (excluding dental appliances [other than intra-oral devices used in connection with the treatment of Temporomandibular Joint Dysfunction and Related Disorders, subject to specific limitations applicable to Temporomandibular Joint Dysfunction and Related Disorders,]and replacement of cataract lenses when a prescription change is not required). 20.51

- Chiropractic and osteopathic manipulation—Benefits will be provided for manipulation or adjustment of osseous or articular structures, commonly referred to as chiropractic and osteopathic manipulation, when performed by a person licensed to perform such procedures.[Your benefits for chiropractic and osteopathic manipulation will be limited to a maximum of $[100–20,000] per benefit period.] 20.37a

- Acupuncture—Benefits will be provided for acupuncture[, limited to a maximum of [$[100–20,000]][[5–365] visits] per benefit period].] **New**

- Optometric services—Benefits will be provided for services which may be legally rendered by an Optometrist, provided that benefits would have been provided had such services been rendered by a Physician.

- Occupational Therapy—Benefits will be provided for Occupational Therapy when these services are rendered by a Physician or by a registered occupational therapist under the supervision of a Physician. This therapy must be furnished under a written plan established by a Physician and regularly reviewed by the therapist and the Physician. The plan must be established before treatment is begun and must relate to the type, amount, frequency and duration of therapy and indicate the diagnosis and anticipated goals. Benefits for Outpatient Occupational Therapy will be limited to a maximum of $[100–20,000] per benefit period.[Your benefits for Occupational Therapy, Physical Therapy and Speech Therapy are limited to a combined maximum of[[20–365] visits] [$[1,000–60,000]] per benefit period.] **New 9/09**

- Speech Therapy—Benefits will be provided for Speech Therapy when these services are rendered by a licensed speech therapist or speech therapist certified by the American Speech and Hearing Association. Inpatient Speech Therapy benefits will be provided only if Speech Therapy is not the only reason for admission. [Outpatient Speech Therapy benefits will be limited to a maximum of $[100–20,000] per benefit period [However, benefits will be provided for an additional [20–365] visits for Speech Therapy for treatment of pervasive developmental disorders.].[Your benefits for Occupational Therapy, Physical Therapy and Speech Therapy are limited to a combined maximum of [[20–365] visits][$[1,000–60,000]] per benefit period. However, benefits will 20.35 **New 9/09**

be provided for an additional 20[20–365] visits for Speech Therapy for treatment of pervasive developmental disorders]

- Naprapathic Service—Benefits will be provided for Naprapathic Services when rendered by a Naprapath.[Benefits for Naprapathic Services will be limited to a maximum of $[200–60,000] per benefit period.]][20.58
- Outpatient drugs and medicines—All drugs and medicines, except drugs used for cosmetic purposes (including, but not limited to, Retin-A/Tretinoin and Minoxidil/Rogaine) which require by law a written prescription and which are dispensed by a Pharmacy or Physician. In addition, your coverage includes benefits for insulin and insulin syringes even though a prescription may not be required by law.] 20.31
- Wigs—Benefits will be provided for wigs (also known as cranial prostheses) when your hair loss is due to Chemotherapy, radiation therapy or alopecia.[Benefits for wigs will be limited to [a lifetime maximum of] $[100–5,000] [per benefit period.]] **New**

BENEFIT PAYMENT FOR OTHER COVERED SERVICES

Benefits will be provided at [50–100]% of the Eligible Charge or Usual and Customary Fee for any of the Covered Services described in this section[after you have met your program deductible].[Your program deductible will not apply.] 20.32

SPECIAL CONDITIONS AND PAYMENTS

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

HUMAN ORGAN TRANSPLANTS

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

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

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

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

Benefits will be provided for:

— Inpatient and Outpatient Covered Services related to the transplant Surgery.

— the evaluation, preparation and delivery of the donor organ.

— the removal of the organ from the donor.

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

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

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

— If 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 [30–200] 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 $[100–5,000] per day.][20.721a
- You and your companion are each entitled to benefits for lodging up to a combined maximum of $[100–5,000] per day.][20.721b
- Benefits for transportation, lodging and meals are limited to a maximum of $[1,000–30,000] per transplant.][20.722a
- Benefits for transportation, lodging and meals are limited to a lifetime maximum of $[1,000–30,000].] 20.722b

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

- Cardiac rehabilitation services when not provided to the transplant recipient immediately following discharge from a Hospital for transplant Surgery.
- Travel time and related expenses required by a Provider.
- Drugs which do not have approval of the Food and Drug Administration.
- Storage fees.
- Services provided to any individual who is not the recipient or actual donor, unless otherwise specified in this provision.

[Your benefits for heart, lung, heart/lung, liver, pancreas and pancreas/kidney transplants are subject to a lifetime maximum of $[250,000–10,000,000]. This lifetime maximum is separate from your lifetime maximum for all other benefits.] 20.41

CARDIAC REHABILITATION SERVICES

Your benefits for cardiac rehabilitation services are the same as your benefits for any other condition. Benefits will be provided for cardiac rehabilitation services only in Blue Cross and Blue Shield approved programs. Benefits are available if you have a history of any of the following: acute myocardial infarction, coronary artery bypass graft Surgery, percutaneous transluminal coronary angioplasty, heart valve Surgery, heart transplantation, stable angina pectoris, compensated heart failure or transmyocardial revascularization. Benefits will be limited to a maximum of 36 Outpatient treatment sessions within a six month period.

SKILLED NURSING FACILITY CARE

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

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

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.

Benefits for Covered Services rendered in a Plan Skilled Nursing Facility will be provided at [50–100]% of the Eligible Charge[after you have met your program deductible]. 20.42

Benefits for Covered Services rendered in a Non-Plan Skilled Nursing Facility will be provided at [50–100]% of the Eligible Charge[, once you have met your program

deductible].[Benefits will not be provided for Covered Services received in an Uncertified Skilled Nursing Facility.] 20.431 20.43

[Each time you are admitted to a Skilled Nursing Facility, you are entitled to benefits for [5–365] days of care.] 20.42a

[You are entitled to benefits for [5–365] days of care in a Skilled Nursing Facility per benefit period.] 20.42b

AMBULATORY SURGICAL FACILITY

Benefits for all of the Covered Services previously described in this Certificate are available for Outpatient Surgery. In addition, benefits will be provided if these services are rendered by an Ambulatory Surgical Facility. Benefits for services rendered by a Plan Ambulatory Surgical Facility will be provided at [50–100]% of the Eligible Charge. Benefits for services by a Non-Plan Ambulatory Surgical Facility will be provided at [50–100]% of the Eligible Charge. 20.44

[Benefits for Outpatient Surgery will be provided as stated above whether or not you have met your program deductible.] 20.441

[Benefits for Outpatient Surgery will be provided as stated above after you have met your program deductible.] 20.442

[WELLNESS CARE

[Benefits will be provided for Covered Services rendered to persons age [one–21] and over, even though you are not ill. Benefits will be limited to the following services:] 20.57a

[Benefits will be provided for Covered Services rendered to you, even though you are not ill. Benefits will be limited to the following services:] 20.57b

1. Immunizations[for children under age [one–21]]; 20.575
2. Routine physical examinations[– [one, 2] per benefit period];[20.576
3. Routine gynecological examinations[– [one, 2] per benefit period];] 20.5761 20.56711
4. [Routine vision examinations[– [one, 2] per benefit period];] **New**
5. Routine diagnostic tests (other than routine mammograms),[ordered or received on the same day as the examination.] Benefits for routine mammograms will be provided at the benefit payment level described under the ROUTINE MAMMOGRAMS provision in this section of this Certificate. 20.5762 **Revised**

When you receive Covered Services for wellness care from a Participating Hospital, benefits for wellness care will be provided at [50–100]% of the Eligible Charge[after you have met your program deductible][and will not be subject to the program deductible]. 20.571 20.572

When you receive Covered Services for wellness care from a Non-Participating Hospital, benefits will be provided at [50–100]% of the Eligible Charge[after you have met your program deductible][and will not be subject to the program deductible]. 20.571 20.572

When you receive Covered Services from a Physician, benefits for wellness care will be provided at [50–100]% of the Usual and Customary Fee[after you have met your program deductible][and will not be subject to the program deductible]. 20.571 20.572

[When you receive Covered Services in your Physician's office, benefits for office visits are subject to a Copayment of $[5–100] per visit.] 20.573

[Benefits for wellness care will be limited to a maximum of $[100–5,000] per benefit period. 20.574 20.57

The following Covered Services are not subject to the wellness care benefit maximum: Pap smear test, prostate test and digital rectal examination, colorectal cancer screening, ovarian cancer screening, clinical breast examination, human papillomavirus vaccine and shingles vaccine.]] **Revised**

[SUBSTANCE ABUSE REHABILITATION TREATMENT 20.4SA

[Benefits for all of the Covered Services previously described in this Certificate are available for Substance Abuse Rehabilitation Treatment. In addition, benefits will be provided if these Covered Services are rendered by a Substance Abuse Treatment Facility. Benefits will be provided at the payment levels described later in this benefit section.] **prior to 10/3/09 or MHP does not apply**

[Your benefits for Substance Abuse Rehabilitation Treatment are the same as your benefits for any other condition. In addition, benefits will be provided if Covered Services are rendered by a Substance Abuse Treatment Facility. Substance Abuse Rehabilitation Treatment Covered Services rendered in a program that does not have a written agreement with Blue Cross and Blue Shield or in a Non-Plan Provider facility will be paid at the Non-Plan Provider facility payment level.]] **New – MHP 10/3/09 – 7/1/10**

Benefits for all of the Covered Services described in this Certificate are available for Substance Abuse Rehabilitation Treatment. In addition, benefits will be provided if these Covered Services are rendered by a Behavioral Health Practitioner in a Substance Abuse Treatment Facility. Substance Abuse Rehabilitation Treatment Covered Services rendered in a program that does not have a written agreement with Blue Cross and Blue Shield or in a Non-Plan Provider facility will be paid at the Non-Plan Provider facility payment level.][**New – MHP Final Regs 7/1/10 & after**

[MENTAL ILLNESS SERVICES 20.4MI

[Benefits for all of the Covered Services described in this Certificate are available for the diagnosis and/or treatment of a Mental Illness. Medical Care for the treatment of a Mental Illness is eligible when rendered by (1) a Physician; (2) a Psychologist; (3) a Clinical Social Worker; (4) a Clinical Professional Counselor or (5) a Marriage and Family Therapist working within the scope of their license.] **prior to 10/3/09 or MHP does not apply**

[Your benefits for the diagnosis and/or treatment of a Mental Illness are the same as your benefits for any other condition. Medical Care for the treatment of a Mental Illness is eligible when rendered by (1) a Physician; (2) a Psychologist; (3) a Clinical Social Worker; (4) a Clinical Professional Counselor or (5) a Marriage and Family Therapist working within the scope of their license.]] **New – MHP 10/3/09 – 7/1/10**

[MENTAL ILLNESS AND SUBSTANCE ABUSE SERVICES

Benefits for all of the Covered Services described in this Certificate are available for the diagnosis and/or treatment of a Mental Illness and/or Substance Abuse disorders. Medical Care for the treatment of a Mental Illness or Substance Abuse disorder is eligible when rendered by a Behavioral Health Practitioner working within the scope of their license.] **Revised – MHP Final Regs 7/1/10 & after**

[CHRONIC CONDITION MANAGEMENT

Benefits will be provided for services for the management of prescription drugs prescribed as part of psychiatric care, including the prescription, use and review of medication with no more than minimal medical psychotherapy.] 20.55b

[Benefit Payment for Outpatient treatment of Mental Illness and Substance Abuse Rehabilitation Treatment

Benefits for Outpatient treatment of Serious Mental Illness will be provided at the payment levels previously described in this Certificate for Hospital and Physician Covered Services.

[Benefits for Outpatient treatment of Mental Illness for those illnesses not classified as Serious Mental Illness will be provided at [50–100]% of the Eligible Charge (in either a Participating or Non-Participating Hospital) or at [50–100]% of the Usual and Customary Fee[after you have met your program deductible].

Benefits for Outpatient Substance Abuse Rehabilitation Treatment (in a program that has a written agreement with Blue Cross and Blue Shield) will be provided at [50–100]% of the Eligible Charge or at [50–100]% of the Usual and Customary Fee[after you have met your program deductible].] 20.50a

[Benefits for Outpatient treatment of Mental Illness for those illnesses not classified as Serious Mental Illness will be provided at [50–100]% of the Eligible Charge (in either a Participating or Non-Participating Hospital) or at [50–100]% of the Usual and Customary Fee for the first [5–365] visits per benefit period[after you have met your program deductible], thereafter benefits will be provided at 50% of the Eligible Charge or at 50% of the Usual and Customary Fee. 20.50b

Benefits for Outpatient Substance Abuse Rehabilitation Treatment (in a program that has a written agreement with Blue Cross and Blue Shield) will be provided at [50–100]% of the Eligible Charge or at [50–100]% of the Usual and Customary Fee for the first [5–365] visits per benefit period[after you have met your program deductible], thereafter benefits will be provided at 50% of the Eligible Charge or at 50% of the Usual and Customary Fee.] 20.50b

[When you receive Covered Services for the Outpatient treatment of Mental Illness or Substance Abuse Rehabilitation Treatment (in a program that does not have a written agreement with Blue Cross and Blue Shield) or in a Non-Plan Provider facility, benefits will be provided at 50% of the Eligible Charge[after you have met your program deductible].] 20.533a

[When you receive Covered Services for the Outpatient treatment of Mental Illness or Substance Abuse Rehabilitation Treatment (in a program that does not have an agreement with Blue Cross and Blue Shield) or in a Non-Plan Provider facility, benefits will be provided at the same payment level as Non-Participating Hospital Covered Services.]] 20.533b

[Benefit Maximum for Outpatient [treatment of Mental Illness][and] [Substance Abuse Rehabilitation Treatment] 20.501

[Your benefits for Outpatient treatment of Serious Mental Illness are limited to a maximum of [60–365] visits per benefit period.] 20.501d

[Your benefits for Outpatient treatment of Mental Illness for those illnesses not classified as Serious Mental Illness and Outpatient Substance Abuse Rehabilitation Treatment are limited to a combined maximum of [5–365] visits per benefit period.] 20.501b

[Your benefits for Outpatient treatment of Mental Illness for those illnesses not classified as Serious Mental Illness are limited to a maximum of [5–365] visits per benefit period.] 20.501c

[Your benefits for Outpatient Substance Abuse Rehabilitation Treatment are limited to a maximum of [5–365] visits per benefit period.] 20.501c

[Your benefits for Outpatient Substance Abuse Rehabilitation Treatment are limited to a maximum of $[500–100,000] per benefit period.]] 20.501a

[Benefit Payment for Inpatient [treatment of Mental Illness][and] [Substance Abuse Rehabilitation Treatment]

Benefits for the Inpatient treatment of Serious Mental Illness will be provided at the payment levels previously described in this Certificate for Hospital and Physician Covered Services.

[Benefits for the Inpatient treatment of Mental Illness for those illnesses not classified as Serious Mental Illness and Inpatient Substance Abuse Rehabilitation Treatment will be provided at the payment levels previously described in this Certificate for Hospital and Physician Covered Services.] 20.53a

[Benefits for the Inpatient treatment of Mental Illness for those illnesses not classified as Serious Mental Illness and Inpatient Substance Abuse Rehabilitation Treatment (in a program that has a written agreement with Blue Cross and Blue Shield) will be provided at [50–100]% of the Eligible Charge for the first [5–365] days of each admission[after you have met your program deductible], thereafter any remaining eligible Hospital charges will be paid at 50% of the Eligible Charge when you receive Covered Services in a Participating Hospital or Plan facility.] 20.531a

[Benefits for the Inpatient treatment of Mental Illness for those illnesses not classified as Serious Mental Illness and Inpatient Substance Abuse Rehabilitation Treatment (in a program that has a written agreement with Blue Cross and Blue Shield) will be provided at [50–100]% of the Eligible Charge [after you have met your program deductible]when you receive Covered Services in a Participating Hospital or Plan facility.] 20.531b

[Benefits for the Inpatient treatment of Mental Illness for those illnesses not classified as Serious Mental Illness and Inpatient Substance Abuse Rehabilitation Treatment (in a program that has a written agreement with Blue Cross and Blue Shield) will be provided at [50–100]% of the Eligible Charge for the first [5–365] days of each admission[after you have met your program deductible], thereafter any remaining eligible Hospital charges will be paid at 50% of the Eligible Charge when you receive Covered Services in a Non-Participating Hospital.] 20.532a

[Benefits for the Inpatient treatment of Mental Illness for those illnesses not classified as Serious Mental Illness and Inpatient Substance Abuse Rehabilitation Treatment (in a program that has a written agreement with Blue Cross and Blue Shield) will be provided at 50% of the Eligible Charge[after you have met your program deductible]when you receive Covered Services in a Non-Participating Hospital.] 20.532b

[When you receive Covered Services for the Inpatient treatment of Mental Illness for those illnesses not classified as Serious Mental Illness or Substance Abuse Rehabilitation Treatment (in a program that does not have a written agreement with Blue Cross and Blue Shield) or in a Non-Plan Provider facility benefits will be provided at 50% of the Eligible Charge[after you have met your program deductible].] 20.533a

[When you receive Covered Services for the Inpatient treatment of Mental Illness for those illnesses not classified as Serious Mental Illness or Substance Abuse Rehabilitation Treatment (in a program that does not have a written agreement with Blue Cross and Blue Shield) or in a Non-Plan Provider facility, benefits will be provided at the same payment level as Non-Participating Hospital Covered Services.] 20.533b

[When you receive Covered Services for the Inpatient treatment of Mental Illness for those illnesses not classified as Serious Mental Illness or Inpatient Substance Abuse Rehabilitation Treatment from a Physician or other professional Provider, benefits will be provided at [50–100]% of the Usual and Customary Fee[after you have met your program deductible].] 20.534 20.53b

[**Benefit Maximum for Inpatient [treatment of Mental Illness][and][Substance Abuse Rehabilitation Treatment**]

[You are entitled to a maximum of [45–365] Inpatient Hospital days each benefit period for Inpatient treatment of Serious Mental Illness.] 20.46d

[You are entitled to a combined maximum of [5–365] Inpatient Hospital days each benefit period for Inpatient treatment of Mental Illness for those illnesses not classified as Serious Mental Illness and Inpatient Substance Abuse Rehabilitation Treatment.] 20.46a

[You are entitled to a maximum of [5–365] Inpatient Hospital days each benefit period for Inpatient treatment of Mental Illness for those illnesses not classified as Serious Mental Illness.] 20.46b

[You are entitled to a maximum of [5–365] Inpatient Hospital days each benefit period for Inpatient Substance Abuse Rehabilitation Treatment.] 20.46b

[Your benefits for Inpatient Substance Abuse Rehabilitation Treatment are limited to a maximum of $[500–750,000] per benefit period.]] 20.46c

[**Lifetime Benefit Maximum for [treatment of Mental Illness][and][Substance Abuse Rehabilitation Treatment**]

[You are entitled to a combined lifetime maximum of [10–1,000] Inpatient Hospital days for Inpatient treatment of Mental Illness for those illnesses not classified as Serious Mental Illness and Substance Abuse Rehabilitation Treatment.] 20.471

[You are entitled to a lifetime maximum of [10–1,000] Inpatient Hospital days for Inpatient treatment of Mental Illness for those illnesses not classified as Serious Mental Illness.] 20.496

[You are entitled to a lifetime maximum of [10–1,000] Inpatient Hospital days for Inpatient Substance Abuse Rehabilitation Treatment.] 20.497a

[A lifetime maximum of $[500–750,000] will apply to benefits for Inpatient Substance Abuse Rehabilitation Treatment.] 20.497b

[You are entitled to a combined lifetime maximum of [10–1,000] Outpatient visits for Outpatient treatment of Mental Illness for those illnesses not classified as Serious Mental Illness and Substance Abuse Rehabilitation Treatment.] 20.473

[You are entitled to a lifetime maximum of [10–1,000] Outpatient visits for Outpatient treatment of Mental Illness for those illnesses not classified as Serious Mental Illness.] 20.494

[You are entitled to a lifetime maximum of [10–1,000] Outpatient visits for Outpatient Substance Abuse Rehabilitation Treatment.] 20.495a

[A lifetime maximum of $[500–750,000] will apply to benefits for Outpatient Substance Abuse Rehabilitation Treatment.] 20.495b

[A combined lifetime maximum of $[500–750,000] will apply to benefits for Inpatient and Outpatient Substance Abuse Rehabilitation Treatment.]] 20.472

[None of the charges for the Inpatient and/or Outpatient treatment of Mental Illness for those illnesses not classified as Serious Mental Illness or Substance Abuse Rehabilitation Treatment will be included in the calculation of your out-of-pocket expenses.]

[BENEFIT PAYMENT FOR MENTAL ILLNESS, SUBSTANCE ABUSE REHABILITATION TREATMENT AND CHRONIC CONDITION MANAGEMENT

Your benefits for the treatment of Mental Illness, Substance Abuse Rehabilitation treatment and Chronic Condition Management are determined differently than the other benefits described in this Certificate. The benefit payment for the treatment of Mental Illness, Substance Abuse Rehabilitation treatment and Chronic Condition Management will be determined at the In-Network or Out-of-Network payment level.

Prior to receiving Covered Services for the treatment of Mental Illness, Substance Abuse Rehabilitation treatment or Chronic Condition Management you must, in order to receive maximum In-Network benefits, contact the Blue Cross and Blue Shield Mental Health Unit at 1-800-851-7498. When you contact the Blue Cross and Blue Shield Mental Health Unit, you will be referred to a specific Professional Provider for treatment.

Benefits for the treatment of Mental Illness, Substance Abuse Rehabilitation Treatment and Chronic Condition Management will be provided at the In-Network payment level only if you contact the Blue Cross and Blue Shield Mental Health Unit prior to receiving Covered Services and receive Covered Services from the Professional Provider to whom you have been referred by the Blue Cross and Blue Shield Mental Health Unit.

Benefits for the treatment of Mental Illness, Substance Abuse Rehabilitation Treatment and Chronic Condition Management will be provided at the Out-of-Network payment level if you contact the Blue Cross and Blue Shield Mental Health Unit but do not receive Covered Services from the Professional Provider to whom you have been referred by the Blue Cross and Blue Shield Mental Health Unit.

If you do not contact the Blue Cross and Blue Shield Mental Health Unit prior to receiving Covered Services for the treatment of Mental Illness, Substance Abuse Rehabilitation Treatment and Chronic Condition Management, benefits will be reduced by $ and paid at the Out-of-Network payment level.

[Outpatient Mental Illness Treatment

Benefits for the Outpatient treatment of Serious Mental Illness will be provided at the Participating Hospital payment levels previously described in this Certificate for Outpatient Hospital Covered Services when you receive Covered Services In-Network.

Benefits for the Outpatient treatment of Serious Mental Illness will be provided at the Physician payment levels previously described in this Certificate for Physician Covered Services when you receive Covered Services either In-Network or Out-of-Network.

Benefits for the Outpatient treatment of Serious Mental Illness will be provided at the Non-Participating Hospital payment levels previously described in this Certificate for Outpatient Hospital Covered Services when you receive Covered Services Out-of-Network.

After you have met your program deductible, benefits for Outpatient treatment of Mental Illness for those illnesses not classified as Serious Mental Illness will be provided at [50–100]% of the Eligible Charge or at [50–100]% of the Maximum Allowance when you receive Covered Services In-Network. 20.551

After you have met your program deductible, benefits for Outpatient treatment of Mental Illness for those illnesses not classified as Serious Mental Illness will be provided at [50–100]% of the Eligible Charge or [50–100]% of the Maximum Allowance when you receive Covered Services Out-of-Network. 20.552

[Your benefits for Outpatient treatment of Serious Mental Illness are limited to a maximum of [60–365] visits per benefit period. However, persons age 18 and under are entitled to [60–365] visits per benefit period for the Outpatient treatment of Serious Mental Illness.] 20.5531

[Your benefits for Outpatient treatment of Mental Illness for those illnesses not classified as Serious Mental Illness are limited to a maximum of [5–365] visits per benefit period. However, persons age 18 and under are entitled to [5–365] visits per benefit period for the Outpatient treatment of Mental Illness for those illnesses not classified as Serious Mental Illness.]] 20.553

[**Outpatient Substance Abuse Rehabilitation Treatment**

After you have met your program deductible, benefits for Outpatient Substance Abuse Rehabilitation Treatment will be provided at [50–100]% of the Eligible Charge or at [50–100]% of the Maximum Allowance when you receive Covered Services In-Network. 20.554

When you receive Covered Services (in a program that has a written agreement with Blue Cross and Blue Shield) Out-of-Network for Outpatient Substance Abuse Rehabilitation Treatment, benefits will be provided at [50–100]% of the Eligible Charge or [50–100]% of the Maximum Allowance after you have met your program deductible. 20.555

Benefits for Out-of-Network Substance Abuse Rehabilitation Treatment in a program that does not have a written agreement with Blue Cross and Blue Shield or in a Non-Plan Substance Abuse Treatment Facility will be provided at 50% of the Eligible Charge after you have met your program deductible.

[Your benefits for Outpatient Substance Abuse Rehabilitation Treatment are limited to a maximum of [5–365] visits per benefit period. However, persons age 18 and under are entitled to a maximum of [5–365] visits per benefit period for Outpatient Substance Abuse Rehabilitation Treatment.]] 20.556

[**Chronic Condition Management**

Benefits for the treatment of Chronic Condition Management will be provided at [50–100]% of the Eligible Charge or at [50–100]% of the Maximum Allow-

ance after you have met your program deductible when you receive Covered Services In-Network. When you receive Covered Services Out-of-Network for the treatment of Chronic Condition Management, benefits will be provided at [50–100]% of the Eligible Charge or [50–100]% of the Maximum Allowance after you have met your program deductible.

Your benefits for the treatment of Chronic Condition Management are limited to one visit each month.] 20.557

[**Inpatient Mental Illness and Substance Abuse Rehabilitation Treatment**

Benefits for the Inpatient treatment of Serious Mental Illness will be provided at the Participating Hospital payment levels previously described in this Certificate for Inpatient Hospital Covered Services when you receive Covered Services In-Network.

Benefits for the Inpatient treatment of Serious Mental Illness will be provided at the Physician payment levels previously described in this Certificate for Physician Covered Services when you receive Covered Services either In-Network or Out-of-Network.

Benefits for the Inpatient treatment of Serious Mental Illness will be provided at the Non-Participating Hospital payment levels previously described in this Certificate for Inpatient Hospital Covered Services when you receive Covered Services Out-of-Network.

After you have met your program deductible, benefits for the Inpatient treatment of Mental Illness for those illnesses not classified as Serious Mental Illness and Inpatient Substance Abuse Rehabilitation Treatment will be provided at [50–100]% of the Eligible Charge or at [50–100]% of the Maximum Allowance when you receive Covered Services In-Network. 20.558

After you have met your program deductible, benefits for the Inpatient treatment of Mental Illness for those illnesses not classified as Serious Mental Illness and Inpatient Substance Abuse Rehabilitation Treatment (in a program that has a written agreement with Blue Cross and Blue Shield) will be provided at [50–100]% of the Eligible Charge or at [50–100]% of the Maximum Allowance when you receive Covered Services Out-of-Network. 20.559

When you receive Out-of-Network Covered Services for the Inpatient treatment of Mental Illness or Substance Abuse Rehabilitation Treatment (in a program that does not have a written agreement with Blue Cross and Blue Shield) or in a Non-Plan Provider facility, benefits will be provided at 50% of the Eligible Charge after you have met your program deductible.

[You are entitled to a maximum of [45–365] Inpatient Hospital days each benefit period for the Inpatient treatment of Serious Mental Illness.] 20.5601

[You are entitled to a maximum of [5–365] Inpatient Hospital days each benefit period for the Inpatient treatment of Mental Illness for those illnesses not classified as a Serious Mental Illness and a maximum of [5–365] Inpatient Hospital days each benefit period for Inpatient Substance Abuse Rehabilitation Treatment.] 20.560

[For every two days of care in a Partial Hospitalization Treatment Program, one day is deducted from your Inpatient Hospital days for the treatment of Mental Illness or Substance Abuse Rehabilitation Treatment.]]

[None of the charges for the Inpatient and/or Outpatient treatment of Mental Illness for those illnesses not classified as Serious Mental Illness or Substance Abuse Rehabilitation Treatment will be applied in satisfying your Out-of-Pocket Expense Limit as explained later in this Certificate.]

[Lifetime Maximum for Mental Illness and Substance Abuse Rehabilitation Treatment

[Your benefits for Inpatient and Outpatient Substance Abuse Rehabilitation Treatment are limited to a combined lifetime maximum of $[20,000–100,000]. However, the maximum amount that will be paid for Out-of-Network Inpatient and Outpatient Substance Abuse Rehabilitation Treatment is a combined lifetime maximum of $[20,000–100,000].] 20.561

[A combined lifetime maximum of [30–365] Inpatient Hospital days will apply to benefits for Inpatient treatment of Mental Illness for those illnesses not classified as Serious Mental Illness and Substance Abuse Rehabilitation Treatment.] 20.562

[A combined lifetime maximum of [30–365] Outpatient visits will apply to benefits for Outpatient treatment of Mental Illness for those illnesses not classified as Serious Mental Illness and Substance Abuse Rehabilitation Treatment.]] 20.563 20.55b

AUTISM SPECTRUM DISORDER(S) New 10/09

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

- psychiatric care, including diagnostic services;
- psychological assessments and treatments;
- habilitative or rehabilitative treatments;
- therapeutic care, including behavioral Speech, Occupational and Physical Therapies that provide treatment in the following areas: a) self care and feeding, b) pragmatic, receptive and expressive language, c) cognitive functioning, d) applied behavior analysis (ABA), intervention and modification, e) motor planning and f) sensory processing.

HABILITATIVE SERVICES New 10/09

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

1. A Physician has diagnosed the Congenital, Genetic, or Early Acquired Disorder; and
2. Treatment is administered by a licensed speech–language pathologist, Audiologist, Occupational Therapist, Physical Therapist, Physician, licensed nurse, Optometrist, licensed nutritionist, Clinical Social Worker, or Psychologist upon the referral of a Physician; and

3. Treatment must be Medically Necessary and therapeutic and not Investigational.

[MATERNITY SERVICE

Your benefits for Maternity Service are the same as your benefits for any other condition and are available whether you have Individual Coverage or Family Coverage. Benefits will also be provided for Covered Services rendered by a Certified Nurse-Midwife.

Benefits will be paid for Covered Services received in connection with both normal pregnancy and Complications of Pregnancy. As part of your maternity benefits certain services rendered to your newborn infant are also covered, even if you have Individual Coverage. These Covered Services are: a) the routine Inpatient Hospital nursery charges, b) one routine Inpatient examination as long as this examination is rendered by a Physician other than the Physician who delivered the child or administered anesthesia during delivery and c) one Inpatient hearing screening. (If the newborn child needs treatment for an illness, injury, congenital defect, birth abnormality or a premature birth, benefits will be available for that care from the moment of birth up to the first 31[31–60] days, thereafter, you must add the newborn child to your Family Coverage. You may apply for Family Coverage within 31 days of the date of the birth. Your Family Coverage will then be effective from the date of the birth.) **Revised**

Benefits will be provided for any hospital length of stay in connection with childbirth for the mother or newborn child for no less than 48 hours following a normal vaginal delivery, or no less than 96 hours following a cesarean section. Your Provider will not be required to obtain authorization from Blue Cross and Blue Shield for prescribing a length of stay less than 48 hours (or 96 hours). 20.52a

[Your coverage also includes benefits for elective abortions if legal where performed.]] 20.52a1

[COMPLICATIONS OF PREGNANCY

Benefits will be paid for Covered Services received in connection with Complications of Pregnancy.] 20.52b

[INFERTILITY TREATMENT

Benefits will be provided the same as your benefits for any other condition 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 that a medical condition exists that makes 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; or, efforts to con-

ceive as a result of one year of medically based and supervised methods of conception, including artificial insemination, have failed and are not likely to lead to a successful pregnancy. **Revised**

Unprotected sexual intercourse means sexual union between a male and 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 and includes appropriate measures to ensure the health and safety of sexual partners. **Revised**

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 makes such treatment useless; and

— You have not undergone four completed oocyte retrievals, except that if a live birth followed a completed oocyte retrieval, two more completed oocyte retrievals shall be covered.

Benefits will also be provided for medical expenses of an oocyte or sperm donor for procedures used to retrieve oocytes or sperm and the subsequent procedure 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 that are eligible for coverage under this Certificate in your lifetime is six. 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. **Revised**

Special Limitations

Benefits will not be provided for the following:

1. 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.
2. Selected termination of an embryo; provided, however, termination will be covered where the mother's life would be in danger if all embryos were carried to full term.
3. Expenses incurred for cryo-preservation or storage of sperm, eggs or embryos, except for those procedures which use a cryo-preserved substance.
4. Non-medical costs of an egg or sperm donor.
5. Travel costs for travel within 100 miles of your home or travel costs not Medically Necessary or required by Blue Cross and Blue Shield.
6. Infertility treatments which are deemed Investigational, in writing, by the American Society for Reproductive Medicine or the American College of Obstetricians or Gynecologists.
7. Infertility treatment rendered to your dependents under age 18.

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

plasmic sperm injection procedures must be performed at medical facilities that conform to the American College of Obstetricians and Gynecologists guidelines for in-vitro fertilization clinics or to the American Society for Reproductive Medicine minimal standards for programs of in-vitro fertilization.]

ROUTINE MAMMOGRAMS

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

— one baseline mammogram

— an annual mammogram

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

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

Benefits for routine mammograms when received from a Participating Hospital will be provided at 100% of the Eligible Charge whether or not you have met your program deductible.

Benefits for routine mammograms when received from a Non-Participating Hospital will be provided at [50–100]% of the Eligible Charge [after you have met your program deductible][and will not be subject to the program deductible].

[Benefits for routine mammograms when received from a Physician will be provided at 100% of the [Usual and Customary Fee][whether or not you have met your program deductible]]. **20.223b** 20.223

[Benefits for routine mammograms will not be subject to any [benefit period maximum or]lifetime maximum.] **New**

MASTECTOMY-RELATED SERVICES

Benefits for Covered Services related to mastectomies are the same as for any other condition. Mastectomy-related Covered Services include, but are 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. Inpatient care following a mastectomy for the length of time determined by your 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 48 hours after discharge; and
4. Prostheses and physical complications of all stages of the mastectomy including, but not limited to, lymphedemas.

[TEMPOROMANDIBULAR JOINT DYSFUNCTION AND RELATED DISORDERS

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

[Your benefits for the diagnosis and/or treatment of Temporomandibular Joint Dysfunction and Related Disorders are limited to a lifetime maximum of $[500–100,000].] 20.51a

[However, your benefits for the diagnosis and/or treatment of Temporomandibular Joint Dysfunction and Related Disorders are limited to a benefit period maximum of $500[500–100,000].]] 20.51b 20.51

PAYMENT PROVISIONS

Lifetime Maximum

[The total maximum amount of benefits to which you are entitled under this benefit program is $[250,000–10,000,000]. This is an individual maximum. There is no family maximum. 20.48a

[As you use your benefits, a certain amount will automatically be restored to your lifetime maximum each year. This amount will be $[500–100,000] or the amount you have received in benefits that benefit period, whichever is less.]] 20.48a1

[The total dollar amount that will be available in benefits for you is unlimited, subject to any separate dollar maximums for specific Covered Services described in this Certificate.] 20.48b

[When Covered Services are rendered by a Participating Hospital, Plan Facility, Physician, or other professional Provider the total maximum amount of benefits to which you are entitled under this benefit program is $[250,000–10,000,000]. When you receive Covered Services from a Non-Participating Hospital or Non-Plan Facility, the total maximum amount of benefits to which you are entitled is $[250,000–10,000,000]. These are individual maximums. There is no family maximum.

[As you use your benefits, a certain amount will automatically be restored each year to your lifetime maximum for Covered Services rendered by a Participating Hospital, Plan Facility, Physician or other professional Provider. This amount will be $[500–100,000] or the amount you have received in benefits for such Covered Services that benefit period, whichever is less. No amount will be restored to your lifetime maximum for Covered Services rendered by a Non-Participating Hospital or Non-Plan Facility.]] 20.48c 20.48c1

[Cumulative Benefit Maximums

All benefits payable under this Certificate are cumulative. Therefore, in calculating the benefit maximums payable for a particular Covered Service or in calculating the remaining balance under the Lifetime Maximums, Blue Cross and Blue Shield will include benefit payments under both this and/or any prior or subsequent Blue Cross and Blue Shield Certificate issued to you as an Eligible Person or a dependent of an Eligible Person under this Group.] 20.501

[Out-of-Pocket Expense Limit

If, during one benefit period, your out-of-pocket expense (the amount remaining unpaid after benefits have been provided plus any prior program deductible credit if applicable) equals $[100–20,000], any additional eligible Claims (except for those Covered Services specifically excluded below) during that benefit period will be paid at 100% of the Eligible Charge or Usual and Customary Fee.

This $[100–20,000] may be reached by any combination of:

- [the program deductible(s)] 20.49a14
- the payments for which you are responsible after benefits have been provided
- [any expenses incurred for Covered Services during the last 3 months of the prior benefit period which were or could have been applied to that benefit period's out-of-pocket expense limit] 20.49a17
- [and any unreimbursed expenses incurred for "comprehensive major medical" Covered Services within your prior contract's benefit period, if not completed.]

It does not include:

- [the program deductible(s)] 20.49a15
- [the Inpatient Hospital admission deductible(s)] 20.49a18
- any charges that exceed the Eligible Charge or Usual and Customary Fee
- [the Coinsurance resulting from Covered Services you may receive in a Non-Participating Hospital]
- the Coinsurance resulting from Hospital Services rendered by a Non-Plan Hospital or other Non-Plan Provider facility for Covered Services other than Emergency Accident Care, Emergency Medical Care and Inpatient treatment during the period of time when your condition is serious
- [charges for Covered Services which have a separate dollar maximum specifically mentioned in this Certificate] 20.49a19
- [the Hospital emergency room Copayment] 20.49a20
- [the Copayment for Physician office visits] 20.49a21
- [charges for Covered Services received for the treatment of Mental Illness for those illnesses not classified as Serious Mental Illness and/or Substance Abuse Rehabilitation Treatment] 20.49a13
- [charges for Outpatient prescription drugs] 20.49a16
- Copayments resulting from noncompliance with the provisions of the Medical Services Advisory Program and/or the Blue Cross and Blue Shield Mental Health Unit. 20.49a

[If you have Family Coverage and [2,3] members of your family have reached their out-of-pocket expense limit during one benefit period, then, for the rest of the benefit period, all other family members will have benefits for Covered Services (except for those Covered Services specifically excluded above) provided at 100% of the Eligible Charge or Usual and Customary Fee.] 20.49a11

[If you have Family Coverage and your expense as described above equals $[200–60,000] during one benefit period, then, for the rest of the benefit period, all other family members will have benefits for eligible Covered Services (except for those Covered Services specifically excluded above) provided at 100% of the Eligible Charge or Usual and Customary Fee. A member may not apply more than the individual out-of-pocket expense limit toward this amount.]] 20.49a12

[OUT-OF-POCKET EXPENSE LIMIT

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

For Participating Hospitals

If, during one benefit period, your out-of-pocket expense (the amount remaining unpaid after benefits have been provided [plus any prior deductible credit, if applicable]) [equals $[100–20,000][equals the out-of-pocket expense limit in the Benefit Highlights (an insert) of this Certificate], any additional eligible Claims (except for those Covered Services specifically excluded below) during that benefit period will be paid at 100% of the Eligible Charge or Usual and Customary Fee.

This out-of-pocket expense limit may be reached by:

- [the program deductible] 20.491
- the payments for which you are responsible after benefits have been provided (except for any expenses incurred for Covered Services rendered by a Non-Participating Hospital, Non-Plan Hospital or other Non-Plan Provider facility other than Emergency Accident Care, Emergency Medical Care and Inpatient treatment during the period of time when your condition is serious)
- [any expenses incurred for Covered Services during the last 3 months of the prior benefit period which were or could have been applied to that benefit period's out-of-pocket expense limit for Participating Hospitals] 20.49b1
- [and any unreimbursed expenses incurred for "comprehensive major medical" Covered Services within your prior contract's benefit period, if not completed.] 20.496

It does not include:

- [the program deductible] 20.492
- [the Inpatient Hospital admission deductible(s)] 20.49b2
- charges that exceed the Eligible Charge or Usual and Customary Fee
- the Coinsurance and/or Copayment resulting from Covered Services rendered by a Non-Participating Hospital, Non-Plan Hospital or other Non-Plan Provider facility
- [charges for Covered Services which have a separate dollar maximum specifically mentioned in this Certificate] 20.49b3
- [charges for Covered Services for the treatment of Mental Illness for those illnesses not classified as Serious Mental Illness or Substance Abuse Rehabilitation Treatment] 20.499
- [the Copayment for Physician office visits] 20.498

- [charges for Outpatient prescription drugs] 20.494b
- Copayments resulting from noncompliance with the provisions of the Medical Services Advisory Program and/or the Blue Cross and Blue Shield Mental Health Unit
- [and any unreimbursed expenses incurred for "comprehensive major medical" Covered Services within your prior contract's benefit period, if not completed.]] 20.497

[If you have Family Coverage and [2,3] members of your family have reached their out-of-pocket expense limit during one benefit period, then, for the rest of the benefit period, all other family members will have benefits for Covered Services (except for those Covered Services specifically excluded above) provided at 100% of the Eligible Charge or Usual and Customary Fee.] 20.493a

[If you have Family Coverage and your expense as described above equals $[200–60,000] during one benefit period, then, for the rest of the benefit period, all other family members will have benefits for eligible Covered Services (except for those Covered Services specifically excluded above) provided at 100% of the Eligible Charge or Usual and Customary Fee. A member may not apply more than the individual out-of-pocket expense limit toward this amount.] 20.493b

For Non-Participating Hospitals

If, during one benefit period, your out-of-pocket expense (the amount remaining unpaid after benefits have been provided) [equals $[100–20,000]][equals the out-of-pocket expense limit in the Benefit Highlights (an insert) of this Certificate], any additional eligible Claims for Covered Services rendered by a Non-Participating Hospital (except for those Covered Services specifically excluded below) during that benefit period will be paid at 100% of the Eligible Charge.

This out-of-pocket expense limit may be reached by:

- [the Non-Participating Hospital program deductible] 20.491
- the payments for Covered Services rendered by a Non-Participating Hospital for which you are responsible after benefits have been provided
- [any expenses incurred for Covered Services during the last 3 months of the prior benefit period which were or could have been applied to that benefit period's out-of-pocket expense limit for Non-Participating Providers] 20.49b1

It does not include:

- [the program deductible] 20.492
- [the Inpatient Hospital admission deductible] 20.495
- charges that exceed the Eligible Charge or Usual and Customary Fee
- the Coinsurance and/or Copayment resulting from Covered Services you may receive from a Participating Hospital or Plan Provider facility or from a Physician or other professional Provider
- the Coinsurance and/or Copayment resulting from Hospital Covered Services rendered by a Non-Plan Hospital or other Non-Plan Provider
- charges for Covered Services which have a separate dollar maximum specifically mentioned in this Certificate 20.49b3

- [charges for Covered Services for the treatment of Mental Illness for those illnesses not classified as Serious Mental Illness or Substance Abuse Rehabilitation Treatment] 20.499
- [the Copayment for Physician office visits] 20.498
- [charges for Outpatient Prescription Drugs] 20.494b
- Copayments resulting from noncompliance with the provisions of the Medical Services Advisory Program and/or the Blue Cross and Blue Shield Mental Health Unit
- [any unreimbursed expenses incurred for "comprehensive major medical" Covered Services within your prior contract's benefit period.] 20.49b

[If you have Family Coverage and [2,3] members of your family have reached their out-of-pocket expense limit during one benefit period, then, for the rest of the benefit period, all other family members will have benefits for Covered Services rendered by a Non-Participating Hospital (except for those Covered Services specifically excluded above) provided at 100% of the Eligible Charge or Usual and Customary Fee.] 20.493a

[If you have Family Coverage and your expense as described above equals $[200–60,000] during one benefit period, then, for the rest of the benefit period, all other family members will have benefits for eligible Covered Services rendered by a Non-Participating Hospital (except for those Covered Services specifically excluded above) provided at 100% of the Eligible Charge or Usual and Customary Fee. A member may not apply more than the individual out-of-pocket expense limit toward this amount.]] 20.493b

EXTENSION OF BENEFITS IN CASE OF TERMINATION

If you are an Inpatient at the time your coverage under this Certificate is terminated, benefits will be provided for, and limited to, the Covered Services of this Certificate which are rendered by and regularly charged for by a Hospital, Skilled Nursing Facility, Substance Abuse Treatment Facility, Partial Hospitalization Treatment Program or Coordinated Home Care Program. Benefits will be provided until you are discharged or until the end of your benefit period, whichever occurs first.

Your health care benefit program is a Comprehensive Major Medical Program. Your coverage will help you pay for a wide range of Hospital and Physician services as well as many other types of health care services. The following Benefit Sections will explain which services are covered (that is, Covered Services) and the benefits that will be provided for them.

HOSPITAL BENEFIT SECTION

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

The benefits of this section are subject to all of the terms and conditions of this Certificate. Your benefits are also subject to the Preexisting Conditions waiting period. Please refer to the DEFINITIONS, ELIGIBILITY and EXCLUSIONS sections of this Certificate for additional information regarding any limitations and/or special conditions pertaining to your benefits. 0.565

In addition, the benefits described in this section will be provided only when you receive services on or after your Coverage Date and they are rendered upon the direction or under the direct care of your Physician. Such services must be Medically Necessary and regularly included in the Provider's charges.

The level of benefits paid for Hospital Covered Services is generally greater when received in a Plan Hospital or other Plan facility. 10.01

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

INPATIENT CARE

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

Inpatient Covered Services

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

Skilled Nursing Facility Care

The following are Covered Services when you are in a Skilled Nursing Facility.

1. Bed, board and general nursing care.

2. Ancillary services (such as drugs and surgical dressings or supplies).

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 is unsuitable.

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

Preadmission Testing

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

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

Partial Hospitalization Treatment Program

You must be admitted to this program within 72 hours of discharge from a covered Inpatient Hospital admission. Your treatment is considered a continuation of that stay. Benefits are available for this program only if it is a Blue Cross and Blue Shield approved program. No benefits will be provided for services received in a Partial Hospitalization Treatment Program which has not been approved by Blue Cross and Blue Shield. 10.57

Benefits for Covered Services received in a Partial Hospitalization Treatment Program will be provided at the payment level specified for Inpatient treatment of Mental Illness and Inpatient Substance Abuse Rehabilitation Treatment in the SPECIAL CONDITIONS AND PAYMENT section of this Certificate. 10.36b

BENEFIT PAYMENT FOR INPATIENT HOSPITAL COVERED SERVICES

Each benefit period you must satisfy a $ deductible for Inpatient Hospital Covered Services. Your benefit period is a period of one year which begins on January 1st of each year. When you first enroll under this health care benefit program, your first benefit period begins on your Coverage Date and ends on the first December 31st following your Coverage Date. After the deductible, benefits will be provided as follows: 10.111

Benefits will be provided at 100% of the Eligible Charge for Inpatient Hospital Covered Services when you receive these services from a Plan Hospital, up to $ each benefit period. Any remaining Eligible Charges will be paid at % of the Eligible Charge. If you are in a private room, benefits will be based on the Plan Hospital's rate for its most common type of room with two or more beds. 10.112

When you receive Covered Services from a Non-Plan Hospital, benefits will be 50% of the Eligible Charge.

However, benefits for an Inpatient Hospital admission to a Non-Plan Hospital resulting from Emergency Accident Care or Emergency Medical Care will be provided at the same payment level which you would have received had you been in a Plan Hospital for that portion of your Inpatient Hospital stay during which your condition is

reasonably determined by Blue Cross and Blue Shield to be serious and therefore not permitting your safe transfer to a Plan Hospital or other Plan Provider.

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

In order for you to continue to receive benefits at the Plan Hospital payment level following an emergency admission to a Non-Plan Hospital, you must transfer to a Plan Hospital or other Plan Provider as soon as your condition is no longer serious.] 10.113a

[When you receive Covered Services from a Non-Plan Hospital, benefits will be 80% of the amount you would have received had you received such services in a Plan Hospital.] 10.113b

[ABOUT YOUR DEDUCTIBLE

Charges in excess of the Eligible Charge may not be used to satisfy your Inpatient Hospital Covered Services deductible.

If you have any Inpatient Hospital Covered Services expenses during the last three months of a benefit period which were or could have been applied to that benefit period's deductible, these expenses may be applied toward the Inpatient Hospital Covered Services deductible of the next benefit period.

[Should two or more members of your family ever receive Inpatient Hospital Covered Services as a result of injuries received in the same accident, only one Inpatient Hospital Covered Services deductible will be applied against those expenses.] 10.121

[When your group initially purchases this coverage, the people who were members of the Group at that time are entitled to a special credit toward their Inpatient Hospital Covered Services deductible for the first benefit period. This special credit applies to eligible expenses incurred for Inpatient Hospital Covered Services in the prior contract's benefit period, if not completed. Such expenses can be applied toward the deductible for the first benefit period under this coverage. However, this is only true if your Group had similar coverage immediately prior to purchasing this coverage.]] 10.122

[Family Deductible

If you have Family Coverage and [2,3] members of your family have each satisfied their Inpatient Hospital Covered Services deductible, it will not be necessary for anyone else in your family to meet that deductible in that benefit period. That is, for the remainder of that benefit period, no other family members are required to meet an Inpatient Hospital Covered Services deductible before receiving benefits.

[Should two or more members of your family ever receive Inpatient Hospital Covered Services as a result of injuries received in the same accident, only one such deductible will be applied against those Covered Services.]] 10.123 10.12

OUTPATIENT HOSPITAL COVERED SERVICES

The following are Covered Services when received from a Hospital as an Outpatient.

Outpatient Covered Services

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

   In addition to Surgery in a Hospital, benefits will be provided for Outpatient Surgery performed in an Ambulatory Surgical Facility.
2. Radiation therapy treatments
3. Chemotherapy
4. Shock therapy
5. Renal Dialysis Treatments—These treatments are eligible for benefits if you receive them in a Hospital, a Dialysis Facility or in your home under the supervision of a Hospital or Dialysis Facility.
6. Coordinated Home Care—Benefits will be provided for services under a Coordinated Home Care Program.
7. Emergency Accident Care—Treatment must occur within 72 hours of the accident or as soon as reasonably possible.
8. Emergency Medical Care
9. Mammograms
10. Diagnostic Service—when you are an Outpatient and these services are related to Surgery or Medical Care. 10.13
11. Pap Smear Test—Benefits will be provided for an annual routine cervical smear or Pap smear test for females.
12. Prostate Test and Digital Rectal Examination—Benefits will be provided for an annual routine prostate–specific antigen test and digital rectal examination for males.
13. Colorectal Cancer Screening—Benefits will be provided for colorectal cancer screening as prescribed by a Physician, in accordance with the published American Cancer Society guidelines on colorectal cancer screening or other existing colorectal cancer screening guidelines issued by nationally recognized professional medical societies or federal government agencies, including the National Cancer Institute, the Centers for Disease Control and Prevention, and the American College of Gastroenterology.

BENEFIT PAYMENT FOR OUTPATIENT HOSPITAL COVERED SERVICES

100% of the Eligible Charge for these Outpatient Covered Services will be paid when received from a Plan Hospital, Plan Ambulatory Surgical Facility or Plan Dialysis Facility. 10.15

When you receive Covered Services from a Non-Plan Hospital or other Non-Plan Provider, payment will be 50% of the Eligible Charge. Covered Services received for Emergency Accident Care and Emergency Medical Care from a Non-Plan Hospital will be paid at the same payment level which would have been paid had such services been received from a Plan Hospital or other Plan Provider. 10.151a

[When you receive Covered Services from a Non-Plan Hospital or other Non-Plan Provider, payment will be 80% of the amount you would have received had you been in a Plan Hospital.] 10.151b

[However, benefits for Emergency Accident Care and Emergency Medical Care will be provided at 100% of the Eligible Charge when received from a Plan Hospital, other Plan Provider, Non-Plan Hospital or other Non-Plan Provider. Your deductible will not apply to this benefit.] 10.14

[However, benefits for Emergency Accident Care and Emergency Medical Care for Covered Services resulting from criminal sexual assault or abuse will be paid at 100% of the Eligible Charge whether or not you have met your deductible.] 10.16

PHYSICIAN BENEFIT SECTION

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

The benefits of this section are subject to all of the terms and conditions of this Certificate. Your benefits are also subject to the Preexisting Conditions waiting period. Please refer to the DEFINITIONS, ELIGIBILITY and EXCLUSIONS sections of this Certificate for additional information regarding any limitations and/or special conditions pertaining to your benefits. 0.566

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

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

COVERED SERVICES

Surgery

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

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

The following services are also part of your surgical benefits:

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

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

have a medical condition requiring hospitalization or general anesthesia for dental care.

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

Additional Surgical Opinion

Your coverage includes benefits for an additional surgical opinion following a recommendation for elective Surgery. Your benefits will be limited to one consultation and related Diagnostic Service by a Physician. Benefits for an additional surgical opinion consultation and related Diagnostic Service will be provided at 100% of the Usual and Customary Fee, whether or not you have met your deductible. If you request, benefits will be provided for an additional consultation when the need for Surgery, in your opinion, is not resolved by the first consultation. 10.21

Medical Care

Benefits are available for Medical Care visits when:

1. you are an Inpatient in a Hospital, a Skilled Nursing Facility, or Substance Abuse Treatment Facility or
2. you are a patient in a Partial Hospitalization Treatment Program or Coordinated Home Care Program or
3. you visit your Physician's office or your Physician comes to your home (except that no benefits are available for psychiatric care).

No benefits are available under this Benefit Section for the treatment of Mental Illness for those illnesses not classified as Serious Mental Illness or Outpatient Substance Abuse Rehabilitation Treatment. In addition, the treatment of Mental Illness and Substance Abuse Rehabilitation Treatment are subject to the maximums specified in the SPECIAL CONDITIONS AND PAYMENTS section of this Certificate. 10.36a

Your benefits for the Inpatient and Outpatient treatment of Mental Illness and Substance Abuse Rehabilitation Treatment will be provided as described in the SPECIAL CONDITIONS AND PAYMENTS section of this Certificate. 10.36b

Consultations

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

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.

Shock Therapy treatments

Radiation therapy treatments

Chemotherapy

Mammograms

Pap Smear Test—Benefits will be provided for an annual routine cervical smear or Pap smear test for females. Benefits for routine cervical smears or Pap smears will be provided at the same payment level as Outpatient Diagnostic Service.

Prostate Test and Digital Rectal Examination—Benefits will be provided for an annual routine prostate–specific antigen test and digital rectal examination for males.

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

Diagnostic Service—benefits will be provided when you are an Inpatient and those services are related to covered Surgery or Medical Care.

Emergency Accident Care—Treatment must occur within 72 hours of the accident or as soon as reasonably possible.

Emergency Medical Care 10.24

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.

No benefits will be provided for abortions or surgical sterilization procedures. 10.74 10.741 10.742

BENEFIT PAYMENT FOR PHYSICIAN SERVICES

When you receive any of the Covered Services described in this Physician Benefits Section, 100% of the Usual and Customary Fee will be paid. 10.23

Your benefits for the Inpatient and Outpatient treatment of Mental Illness and Substance Abuse Rehabilitation Treatment will be provided as described in the SPECIAL CONDITIONS AND PAYMENTS section of this Certificate. 10.36b

OTHER COVERED SERVICES

OTHER COVERED SERVICES

This section of your Certificate describes ‘‘Other Covered Services’’ and the benefits that will be provided for them.

- Home, office and Outpatient visits—Visits made to a Physician’s office or by a Physician to your home for treatment of an illness or injury. 10.31a
- Home, office and Outpatient visits—Visits made to a Physician’s office or by a Physician to your home for treatment of an illness or injury (except that benefits will not be provided for psychiatric care). 10.31b
- Outpatient drugs and medicines—All drugs and medicines, except contraceptive drugs or drugs used for cosmetic purposes (including, but not limited to, Retin-A/Tretinoin and Minoxidil/Rogaine) which require by law a written prescription and which are dispensed by a Pharmacy or Physician. In addition, your coverage includes benefits for insulin and insulin syringes even though a prescription may not be required by law. 10.321 10.32
- Blood and blood components
- Leg, back, arm and neck braces
- Physical Therapy—Physical Therapy when rendered by a Physician or by a registered professional physical therapist under the supervision of a Physician. The therapy must be furnished under a written plan established by a Physician and regularly reviewed by the therapist and the Physician. The plan must be established before treatment is begun and must relate to the type, amount, frequency and duration of therapy and indicate the diagnosis and anticipated goals. Benefits for Outpatient Physical Therapy will be limited to a maximum of $ per benefit period. 10.51
- Private Duty Nursing Service—Benefits for Private Duty Nursing Service will be provided to you in your home only when the services are of such a nature that they cannot be provided by non-professional personnel and can only be provided by a licensed health care provider. No benefits will be provided when a nurse ordinarily resides in your home or is a member of your immediate family. Private Duty Nursing includes teaching and monitoring of complex care skills such as tracheotomy suctioning, medical equipment use and monitoring to home caregivers and is not intended to provide for long term supportive care. Benefits for Private Duty Nursing Service will not be provided due to the lack of willing or available non-professional personnel. Your benefits for Private Duty Nursing Service will be limited to a maximum of $ per monthbenefit period. 10.56 10.56a 10.56b
- Ambulance Transportation—Benefits will not be provided for long distance trips or for use of an ambulance because it is more convenient than other transportation.
- Dental accident care—Dental services rendered by a Dentist or Physician which are required as the result of an accidental injury.
- Allergy shots and allergy surveys

- Oxygen and its administration
- Medical and surgical dressings, supplies, casts and splints
- Durable medical equipment—Benefits will be provided for such things as internal cardiac valves, internal pacemakers, mandibular reconstruction devices (not used primarily to support dental prosthesis), bone screws, bolts, nails, plates, and any other internal and permanent devices as reasonably approved by Blue Cross and Blue Shield. Benefits will also be provided for the rental (but not to exceed the total cost of equipment) or purchase of durable medical equipment required for temporary therapeutic use provided that this equipment is primarily and customarily used to serve a medical purpose.
- Prosthetic appliances—Benefits will be provided for prosthetic devices, special appliances and surgical implants when:

  a. they are required to replace all or part of an organ or tissue of the human body, or

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

  Benefits will also include adjustments, repair and replacements of covered prosthetic devices, special appliances and surgical implants when required because of wear or change in a patient's condition (excluding dental appliances other than intra-oral devices used in connection with the treatment of Temporomandibular Joint Dysfunction and Related Disorders, subject to specific limitations applicable to Temporomandibular Joint Dysfunction and Related Disorders, and replacement of cataract lenses when a prescription change is not required). 10.54
- Muscle manipulations
- Optometric services—Benefits will be provided for services which may be legally rendered by an Optometrist, provided that benefits would have been provided had such services been rendered by a Physician.
- Occupational Therapy—Benefits will be provided for Occupational Therapy when these services are rendered by a Physician or by a registered occupational therapist under the supervision of a Physician. This therapy must be furnished under a written plan established by a Physician and regularly reviewed by the therapist and the Physician. The plan must be established before treatment is begun and must relate to the type, amount, frequency and duration of therapy and indicate the diagnosis and anticipated goals.Benefits for Outpatient Occupational Therapy will be limited to a maximum of $ per benefit period. 10.52
- Speech Therapy—Benefits will be provided for Speech Therapy when these services are rendered by a licensed speech therapist or speech therapist certified by the American Speech and Hearing Association. Inpatient Speech Therapy benefits will be provided only if Speech Therapy is not the only reason for an admission. Outpatient Speech Therapy benefits will be limited to a maximum of $ per benefit period. 10.53
- Cardiac Rehabilitation Services—Benefits will be provided for cardiac rehabilitation services only in Blue Cross and Blue Shield approved programs when these services are rendered to you within a six month period following an eligi-

ble Inpatient Hospital admission for either myocardial infarction, coronary artery bypass Surgery or percutaneous transluminal coronary angioplasty. Benefits will be limited to a maximum of 36 Outpatient treatment sessions within the six month period.

- Naprapathic Service — Benefits will be provided for Naprapathic Services when rendered by a Naprapath. Benefits for Naprapathic Services will be limited to a maximum of $ per benefit period. 10.58

[$1,000/$2,000/$3,000]

BENEFIT PAYMENT FOR OTHER COVERED SERVICES

Each benefit period you must satisfy a $ deductible for Other Covered Services benefits. Your benefit period is a period of one year which begins on January 1st of each year. When you first enroll under this health care benefit program, your first benefit period begins on your Coverage Date and ends on the first December 31st following your Coverage Date. After this deductible, % of the Eligible Charge or of the Usual and Customary Fee will be paid for Other Covered Services. However, Emergency Accident Care and Emergency Medical Care benefits for Covered Services resulting from criminal sexual assault or abuse will be paid at 100% of the Eligible Charge or Usual and Customary Fee whether or not you have met your deductible. 10.35a

BENEFIT PAYMENT FOR PHYSICIAN AND OTHER COVERED SERVICES

Each benefit period you must satisfy a $ deductible for Physician and Other Covered Services benefits. Your benefit period is a period of one year which begins on January 1st of each year. When you first enroll under this health care benefit program, your first benefit period begins on your Coverage Date and ends on the first December 31st following your Coverage Date. After this deductible, % of the Eligible Charge or of the Usual and Customary Fee will be paid for Physician and Other Covered Services. However, Emergency Accident Care and Emergency Medical Care benefits for Covered Services resulting from criminal sexual assault or abuse will be paid at 100% of the Eligible Charge or Usual and Customary Fee whether or not you have met your deductible. 10.35b

BENEFIT PAYMENT FOR OUTPATIENT HOSPITAL, PHYSICIAN AND OTHER COVERED SERVICES

Each benefit period year you must satisfy a $ deductible for Outpatient Hospital, Physician and Other Covered Services benefits. Your benefit period is a period of one year which begins on January 1st of each year. When you first enroll under this health care benefit program, your first benefit period begins on your Coverage Date and ends on the first December 31st following your Coverage Date. After this deductible, % of the Eligible Charge or of the Usual and Customary Fee will be paid for Outpatient Hospital (Plan Provider only), Physician and Other Covered Services. 10.35c

When you receive Covered Services from a Non-Plan Provider, benefits will be 50% of the Eligible Charge. However, Emergency Accident Care and Emergency Medical Care benefits for Covered Services resulting from criminal sexual assault or abuse will be paid at 100% of the Eligible Charge or Usual and Customary Fee whether or not you have met your deductible. 10.351

When you receive Covered Services from a Non-Plan Provider, benefits will be 80% of the amount you would have received had you received such services from a Plan Provider. However, Emergency Accident Care and Emergency Medical Care benefits for Covered Services resulting from criminal sexual assault or abuse will be paid at 100% of the Eligible Charge or Usual and Customary Fee whether or not you have met your deductible. 10.352 10.35c

ABOUT YOUR DEDUCTIBLE

Charges in excess of the Eligible Charge or the Usual and Customary Fee may not be used to satisfy your deductible. 10.371

If you have any expenses during the last three months of a benefit period which were or could have been applied to that benefit period's deductible, these expenses may be applied toward your deductible for the next benefit period.

Should two or more members of your family ever receive these Covered Services as a result of injuries received in the same accident, only one deductible will be applied against these Covered Services. 10.372

When your Group initially purchases this coverage, the people that were members of the Group at that time are entitled to a special credit toward their deductible of the first benefit period. This special credit applies to expenses incurred for Covered Services in the prior contract's benefit period, if applicable. Such expenses can be applied toward the deductible of the first benefit period. However, this is only true if your Group had similar coverage immediately prior to purchasing this coverage. 10.373

Family Deductible

If you have Family Coverage and members of your family have each satisfied their deductible, it will not be necessary for anyone else in your family to meet that deductible in that benefit period. That is, for the remainder of that benefit period, any other family members are not required to meet a deductible before receiving benefits. 10.374a

If you have Family Coverage and your family has reached the deductible amount of $, it will not be necessary for anyone else in your family to meet a deductible in that benefit period. That is, for the remainder of that benefit period, no other family members are required to meet a deductible before receiving benefits. A family member may not apply more than the individual deductible amount toward the family deductible. 10.374b

Should two or more members of your family ever receive these Covered Services as a result of injuries received in the same accident, only one such deductible will be applied against these Covered Services. 10.374 10.37

SPECIAL CONDITIONS AND PAYMENTS

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

Human Organ Transplants

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

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

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

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

Benefits will be provided for:

— Inpatient and Outpatient Covered Services related to the transplant Surgery.

— the evaluation, preparation and delivery of the donor organ.

— the removal of the organ from the donor.

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

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

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

— If 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. 10.72

- You and your companion are each entitled to benefits for lodging and meals up to a combined maximum of $ per day. 10.721a [$x, $200]
- You and your companion are each entitled to benefits for lodging up to a combined maximum of $ per day. 10.721b [$x, $25]
- Benefits for transportation, lodging and meals are limited to a maximum of $ per transplant. 10.722a [$ x, $10,000]
- Benefits for transportation, lodging and meals are limited to a lifetime maximum of $. 10.722b [$x, $10,000]

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

- Cardiac rehabilitation services when not provided to the transplant recipient immediately following discharge from a Hospital for transplant Surgery.
- Travel time and related expenses required by a Provider.
- Drugs which do not have approval of the Food and Drug Administration.
- Storage fees.
- Services provided to any individual who is not the recipient or actual donor, unless otherwise specified in this provision.

Your benefits for heart, lung, heart/lung, liver, pancreas and pancreas/kidney transplants are subject to a lifetime maximum of $. This lifetime maximum is separate from your lifetime maximum for all other benefits. 10.55

Maternity Service

Your benefits for Maternity Service are the same as your benefits for any other condition and are available whether you have Individual Coverage or Family Coverage. Benefits will also be provided for Covered Services rendered by a Certified Nurse-Midwife.

Benefits will be paid for Covered Services received in connection with both normal pregnancy and Complications of Pregnancy. As part of your maternity benefits certain services rendered to your newborn infant are also covered, even if you have Individual Coverage. These Covered Services are: a) the routine Inpatient nursery charges, b) one routine Inpatient examination as long as this examination is rendered by a Physician other than the Physician who delivered the child or administered anesthesia during delivery and c) one Inpatient hearing screening. (If the newborn child needs treatment for an illness or injury, benefits will be available for that care only if you have Family Coverage. You may apply for Family Coverage within 31 days of the date of the birth. Your Family Coverage will then be effective from the date of the birth.)

Benefits will be provided for any hospital length of stay in connection with childbirth for the mother or newborn child for no less than 48 hours following a normal vaginal delivery, or no less than 96 hours following a cesarean section. Your Provider will not

be required to obtain authorization from Blue Cross and Blue Shield for prescribing a length of stay less than 48 hours (or 96 hours).

Your coverage also includes benefits for elective abortions if legal where performed. 10.73

Infertility

Covered Services related to 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 and low tubal ovum transfer are the same as your benefits for any other condition. Infertility means the inability to conceive a child after one year of unprotected sexual intercourse or the inability to sustain a successful pregnancy.

Benefits for in-vitro fertilization, gamete intrafallopian tube transfer or zygote intrafallopian tube transfer procedures will be provided only when:

— you have been unable to attain or sustain a successful pregnancy through reasonable, less costly medically appropriate infertility treatments; 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.

Special Limitations

Benefits will not be provided for the following:

— Services rendered to a surrogate mother for purposes of child birth

— Expenses incurred for cryo-preservation and storage of sperm, eggs and embryos, except for those procedures which use a cryo-preserved substance

— Non-medical costs of an egg or sperm donor.

In addition to the above provisions, in-vitro fertilization, gamete intrafallopian tube transfer or zygote intrafallopian tube transfer procedures must be performed at medical facilities that conform to the American College of Obstetric and Gynecology guidelines for in-vitro fertilization clinics or to the American Fertility Society minimal standards for programs of in-vitro fertilization.

Temporomandibular Joint Dysfunction and Related Disorders

Benefits for all of the Covered Services previously described in this Certificate are available for the diagnosis and treatment of Temporomandibular Joint Dysfunction and Related Disorders. Your benefits for the diagnosis and/or treatment of Temporomandibular Joint Dysfunction and Related Disorders are limited to a lifetime maximum of $. 10.54a

However, your benefits for the diagnosis and/or treatment of Temporomandibular Joint Dysfunction and Related Disorders are limited to a benefit period maximum of $500. 10.54b 10.54

Mastectomy-Related Services

Benefits for Covered Services related to mastectomies are the same as for any other condition. Mastectomy-related Covered Services include, but are 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. Inpatient care following a mastectomy for the length of time determined by your 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 48 hours after discharge; and
4. Prostheses and physical complications of all stages of the mastectomy including, but not limited to, lymphedemas.

[**Emergency Accident Care**—Treatment must occur within 72 hours of the accident or as soon as reasonably possible.

Emergency Medical Care

BENEFIT PAYMENT FOR EMERGENCY CARE

If you receive Emergency Accident Care or Emergency Medical Care from a Plan or Non-Plan Provider, 100% of the Eligible Charge or Usual and Customary Fee will be paid for these services, whether or not you have met your deductible.] 10.41

[**Outpatient Diagnostic Service**

Benefits will be provided for Diagnostic Service you receive on an Outpatient basis.

Mammograms

BENEFIT PAYMENT FOR OUTPATIENT DIAGNOSTIC SERVICES AND MAMMOGRAMS

[[When you receive Outpatient Diagnostic Services and mammograms from a Plan Hospital, benefits will be provided at [50–100]% of the Eligible Charge. If you receive these services from a Non-Plan Hospital, payment will be 50% of the Eligible Charge.] 10.421a

[When you receive Outpatient Diagnostic Services and mammograms from a Plan Hospital, benefits will be provided at [50–100]% of the Eligible Charge. If you receive these services from a Non-Plan Hospital, payment will be 80% of the amount that would have been paid had such service been received from a Plan Hospital.] 10.421b

When you receive Outpatient Diagnostic Services and mammograms from a Physician (or laboratory), benefits will be provided at [50–100]% of the Usual and Customary Fee.] 10.421

[[When you receive Outpatient Diagnostic Services and mammograms from a Plan Hospital, benefits will be provided at [50–100]% of the Eligible Charge up to

$[100–5,000] each calendar year. If you receive these services from a Non-Plan Hospital, benefits will be 50% of the Eligible Charge.] 10.422a

[When you receive Outpatient Diagnostic Services and mammograms from a Plan Hospital, benefits will be provided at [50–100]% of the Eligible Charge up to $[100–5,000] each calendar year. If you receive these services from a Non-Plan Hospital, benefits will be 80% of the amount that would have been paid had such services been received from a Plan Hospital.] 10.422b

When you receive Outpatient Diagnostic Services and mammograms from a Physician (or laboratory), benefits will be provided at [50–100]% of the Usual and Customary Fee up to $[100–5,000] each benefit period.]] 10.422

[[When you receive Outpatient Diagnostic Services and mammograms from a Plan Hospital benefits will be provided at [50–100]% of the Eligible Charge. If you receive these services from a Non-Plan Hospital, payment will be 50% of the Eligible Charge. If you receive Outpatient Diagnostic Services and mammograms from a Physician (or laboratory), [50–100]% of the Usual and Customary Fee will be paid.] 10.423a

[When you receive Outpatient Diagnostic Services and mammograms from a Plan Hospital benefits will be provided at [50–100]% of the Eligible Charge. If you receive these services from a Non-Plan Hospital, payment will be 80% of the amount that would have been paid had such service been received from a Plan Hospital. If you receive Outpatient Diagnostic Services and mammograms from a Physician (or laboratory), [50–100]% of the Usual and Customary Fee will be paid.] 10.423b

[Both Outpatient Diagnostic Services and mammograms received from a Plan Hospital or from a Physician (or laboratory) will be paid up to a combined maximum of $[100–5,000] each benefit period.]] 10.423 10.42

Substance Abuse Rehabilitation Treatment

Benefits for all of the Covered Services described in this Certificate are available for Substance Abuse Rehabilitation Treatment. In addition, benefits will be provided if these Covered Services are rendered by a Substance Abuse Treatment Facility. Benefits will be provided at the payment levels described later in this benefit section. Substance Abuse Rehabilitation Treatment Covered Services rendered in a program that does not have a written agreement with Blue Cross and Blue Shield or in a Non-Plan Provider facility will be paid at the Non-Plan Provider facility payment level described later in this benefit section.

Mental Illness Services

Benefits for all of the Covered Services previously described in this Certificate are available for the diagnosis and/or treatment of a Mental Illness. Medical Care for the treatment of a Mental Illness is eligible when rendered by (1) a Physician; (2) a Psychologist; (3) a Clinical Social Worker; (4) a Clinical Professional Counselor or (5) a Marriage and Family Therapist working within the scope of their license.

[Chronic Condition Management

Benefits will be provided for services for the management of prescription drugs prescribed as part of psychiatric care, including the prescription, use and review of medication with no more than minimal medical psychotherapy.] 10.36b

[BENEFIT PAYMENT FOR MENTAL ILLNESS AND SUBSTANCE ABUSE REHABILITATION TREATMENT

[Benefits for Outpatient treatment of Serious Mental Illness will be provided at the payment levels previously described in this Certificate for Hospital and Physician Covered Services.

Benefits for Outpatient treatment of Mental Illness for those illnesses not classified as Serious Mental Illness will be provided at [50–100]% of the Eligible Charge or at [50–100]% of the Usual and Customary Fee after you have met your deductible. 10.3612a

Benefits for Outpatient Substance Abuse Rehabilitation Treatment (in a program that has a written agreement with Blue Cross and Blue Shield) will be provided at [50–100]% of the Eligible Charge or at [50–100]% of the Usual and Customary Fee after you have met your deductible. Benefits will be provided for the Outpatient treatment of Substance Abuse Rehabilitation Treatment in a program that does not have a written agreement with Blue Cross and Blue Shield or in a Non-Plan facility at the same level as payment for Non-Plan Hospital Services.] 10.3612a

[Benefits for Outpatient treatment of Mental Illness for those illnesses not classified as Serious Mental Illness will be provided at [50–100]% of the Eligible Charge or at [50–100]% of the Usual and Customary Fee for the first [5–365] visits per benefit period after you have met your deductible, thereafter benefits will be provided at 50% of the Eligible Charge or at 50% of the Usual and Customary Fee. 10.3612b

Benefits for Outpatient Substance Abuse Rehabilitation Treatment (in a program that has a written agreement with Blue Cross and Blue Shield) will be provided at [50–100]% of the Eligible Charge or at [50–100]% of the Usual and Customary Fee for the first [5–365] visits per benefit period after you have met your deductible, thereafter benefits will be provided at 50% of the Eligible Charge or at 50% of the Usual and Customary Fee. Benefits will be provided for Outpatient Substance Abuse Rehabilitation treatment in a program that does not have a written agreement with Blue Cross and Blue Shield or in a Non-Plan facility at 50% of the Eligible Charge after you have met your deductible.] 10.3612b

[Benefit Maximum for Outpatient treatment of Mental Illness and Substance Abuse Rehabilitation Treatment 10.3613

[Your benefits for Outpatient treatment of Mental Illness for those illnesses not classified as Serious Mental Illness and Outpatient Substance Abuse Rehabilitation Treatment are limited to a combined maximum of [5–365] visits per benefit period.] 10.3613a

[Your benefits for Outpatient treatment of Serious Mental Illness are limited to a maximum of [35–365] visits per benefit period.] 10.3613d

[Your benefits for Outpatient treatment of Mental Illness for those illnesses not classified as Serious Mental Illness are limited to a maximum of [5–365] visits per benefit period.] 10.3613b

[Your benefits for Outpatient Substance Abuse Rehabilitation Treatment are limited to a maximum of [5–365] visits per benefit period.] 10.3613b

[Your benefits for the Outpatient treatment of Mental Illness for those illnesses not classified as Serious Mental Illness and Outpatient Substance Abuse Rehabilitation Treatment are limited to a combined maximum of $[500–60,000] per benefit period.]] 10.3613c

[Benefit Payment for Inpatient treatment of Mental Illness and Substance Abuse Rehabilitation Treatment

Benefits for the Inpatient treatment of Serious Mental Illness will be provided at the payment levels previously described in this Certificate for Hospital and Physician Covered Services.

[Benefits for Hospital Covered Services for the Inpatient treatment of Mental Illness for those illnesses not classified as Serious Mental Illness and Inpatient Substance Abuse Rehabilitation Treatment (in a program that has a written agreement with Blue Cross and Blue Shield) will be provided at [50–100]% of the Eligible Charge for the first [5–365] days of each admission after you have met your deductible, thereafter any remaining eligible Hospital charges will be paid at 50% of the Eligible Charge.] 10.3614a

[Benefits for Hospital Covered Services for the Inpatient treatment of Mental Illness for those illnesses not classified as Serious Mental Illness and Inpatient Substance Abuse Rehabilitation Treatment (in a program that has an agreement with Blue Cross and Blue Shield) will be provided at [50–100]% of the Eligible Charge after you have met your deductible.] 10.3614b

[When you receive Covered Services for the Inpatient treatment of Mental Illness for those illnesses not classified as Serious Mental Illness or Substance Abuse Rehabilitation Treatment (in a program that does not have a written agreement with Blue Cross and Blue Shield) or in a Non-Plan Provider facility, benefits will be provided at 50% of the Eligible Charge after you have met your deductible.] 10.3615a

[When you receive Covered Services for the Inpatient treatment of Mental Illness for those illnesses not classified as Serious Mental Illness or Substance Abuse Rehabilitation Treatment (in a program that does not have a written agreement with Blue Cross and Blue Shield) or in a Non-Plan Provider facility, benefit payment will be 80% of the amount you would have received had these services been received from a Plan Provider.] 10.3615b

[When you receive Covered Services for the Inpatient treatment of Mental Illness for those illnesses not classified as Serious Mental Illness or Inpatient Substance Abuse Rehabilitation Treatment from a Physician, Psychologist, Clinical Social Worker or Clinical Professional Counselor, benefits will be provided at [50–100]% of the Usual and Customary Fee after you have met your deductible.]] 10.3616

[Benefit Maximum for Inpatient treatment of Mental Illness and Substance Abuse Rehabilitation Treatment

[You are entitled to a combined maximum of [5–365] Inpatient Hospital days each benefit period for Inpatient treatment of Mental Illness for those illnesses not classified as Serious Mental Illness and Inpatient Substance Abuse Rehabilitation Treatment.] 10.3617a

[You are entitled to a maximum of [45–365] Inpatient Hospital days each benefit period for Inpatient treatment of Serious Mental Illness.] 10.3617d

[You are entitled to a maximum of [5–365] Inpatient Hospital days each benefit period for Inpatient treatment of Mental Illness for those illnesses not classified as Serious Mental Illness.] 10.3617b

[You are entitled to a maximum of [5–365] Inpatient Hospital days each benefit period for Inpatient Substance Abuse Rehabilitation Treatment.] 10.3617b

[Your benefits for Inpatient treatment of Mental Illness for those illnesses not classified as Serious Mental Illness and Inpatient Substance Abuse Rehabilitation Treatment are limited to a maximum of $[500–100,000] per benefit period.]] 10.3617c

[Lifetime Benefit Maximum for treatment of Mental Illness and Substance Abuse Rehabilitation Treatment

[A combined lifetime maximum of $[500–750,000] will apply to benefits for Inpatient and Outpatient treatment of Mental Illness for those illnesses not classified as Serious Mental Illness and/or Substance Abuse Rehabilitation Treatment.] 10.3618

[You are entitled to a combined lifetime maximum of [10–1,000] Inpatient Hospital days for Inpatient treatment of Mental Illness for those illnesses not classified as Serious Mental Illness and Substance Abuse Rehabilitation Treatment.] 10.3619

[You are entitled to a combined lifetime maximum of [10–1,000] Outpatient visits for Outpatient treatment of Mental Illness for those illnesses not classified as Serious Mental Illness and Substance Abuse Rehabilitation Treatment.]] 10.3620

[None of the charges for the Inpatient and/or Outpatient treatment of Mental Illness for those illnesses not classified as Serious Mental Illness or Substance Abuse Rehabilitation Treatment will be included in the calculation of your out-of-pocket expenses.]

[BENEFIT PAYMENT FOR MENTAL ILLNESS, SUBSTANCE ABUSE REHABILITATION TREATMENT AND CHRONIC CONDITION MANAGEMENT

Your benefits for the treatment of Mental Illness, Substance Abuse Rehabilitation treatment and Chronic Condition Management are determined differently than the other benefits described in this Certificate. The benefit payment for the treatment of Mental Illness, Substance Abuse Rehabilitation treatment and Chronic Condition Management will be determined at the In-Network or Out-of-Network payment level.

Prior to receiving Covered Services or, in the case of an emergency, for the treatment of Mental Illness, Substance Abuse Rehabilitation Treatment or Chronic Condition Management you must, in order to receive maximum benefits, contact the Blue Cross and Blue Shield Mental Health Unit at 1-800-851-7498. When you contact the Blue Cross and Blue Shield Mental Health Unit, you will be referred to a specific Professional Provider for treatment.

Benefits for the treatment of Mental Illness, Substance Abuse Rehabilitation Treatment and Chronic Condition Management will be provided at the In-Network payment level only if you contact the Blue Cross and Blue Shield Mental Health Unit prior to receiving Covered Services and receive Covered Services from the Professional Provider to whom you have been referred by the Blue Cross and Blue Shield Mental Health Unit.

Benefits for the treatment of Mental Illness, Substance Abuse Rehabilitation Treatment and Chronic Condition Management will be provided at the Out-of-

Network payment level if you contact the Blue Cross and Blue Shield Mental Health Unit but do not receive Covered Services from the Professional Provider to whom you have been referred by the Blue Cross and Blue Shield Mental Health Unit.

If you do not contact the Blue Cross and Blue Shield Mental Health Unit prior to receiving Covered Services for the treatment of Mental Illness, Substance Abuse Rehabilitation Treatment and Chronic Condition Management, benefits will be reduced by $ and paid at the Out-of-Network payment level.

[**Outpatient Mental Illness Treatment**

Benefits for the Outpatient treatment of Serious Mental Illness will be provided at the payment levels previously described in this Certificate for Hospital and Physician Covered Services.

[After you have met your deductible, benefits for Outpatient treatment of Mental Illness for those illnesses not classified as Serious Mental Illness will be provided at [50–100]% of the Eligible Charge or at [50–100]% of the Maximum Allowance when you receive Covered Services In-Network.] 10.362

[After you have met your deductible, benefits for Outpatient treatment of Mental Illness for those illnesses not classified as Serious Mental Illness will be provided at [50–100]% of the Eligible Charge or [50–100]% of the Maximum Allowance when you receive Covered Services Out-of-Network.] 10.363

[Your benefits for Outpatient treatment of Serious Mental Illness are limited to a maximum of [35–365] visits per benefit period. However, persons age 18 and under are entitled to [35–365] visits per benefit period for the Outpatient treatment of Serious Mental Illness.] 10.364

[Your benefits for Outpatient treatment of Mental Illness for those illnesses not classified as Serious Mental Illness are limited to a maximum of [5–365] visits per benefit period. However, persons age 18 and under are entitled to [5–365] visits per benefit period for the Outpatient treatment of Mental Illness for those illnesses not classified as Serious Mental Illness.]] 10.364

[**Outpatient Substance Abuse Rehabilitation Treatment**

[After you have met your deductible, benefits for Outpatient Substance Abuse Rehabilitation Treatment will be provided at [50–100]% of the Eligible Charge or at [50–100]% of the Maximum Allowance when you receive Covered Services In-Network.] 10.362

[When you receive Covered Services (in a program that has a written agreement with Blue Cross and Blue Shield) Out-of-Network for Outpatient Substance Abuse Rehabilitation Treatment, benefits will be provided at [50–100]% of the Eligible Charge or [50–100]% of the Maximum Allowance after you have met your deductible.] 10.363

Benefits for Out-of-Network Substance Abuse Rehabilitation Treatment in a program that does not have a written agreement with Blue Cross and Blue Shield or in a Non-Plan Provider facility will be provided at 50% of the Eligible Charge after you have met your deductible.

[Your benefits for Outpatient Substance Abuse Rehabilitation Treatment are limited to a maximum of [5–365] visits per benefit period. However, persons age 18 and under are entitled to a maximum of [5–365] visits per benefit period for Outpatient Substance Abuse Rehabilitation Treatment.]] 10.365

[**Chronic Condition Management**

Benefits for the treatment of Chronic Condition Management will be provided at [50–100]% of the Eligible Charge or at [50–100]% of the Maximum Allowance when you receive Covered Services In-Network. When you receive Covered Services Out-of-Network for the treatment of Chronic Condition Management, benefits will be provided at [50–100]% of the Eligible Charge or [50–100]% of the Maximum Allowance after you have met your deductible.

[Your benefits for the treatment of Chronic Condition Management are limited to [one–10] visit[s] each month.]] 10.366

[**Inpatient Mental Illness and Substance Abuse Rehabilitation Treatment**

Benefits for the Inpatient treatment of Serious Mental Illness will be provided at the payment levels previously described in this Certificate for Hospital and Physician Covered Services.

[After you have met your deductible, benefits for the Inpatient treatment of Mental Illness for those illnesses not classified as Serious Mental Illness and Inpatient Substance Abuse Rehabilitation Treatment will be provided at [50–100]% of the Eligible Charge or at [50–100]% of the Maximum Allowance when you receive Covered Services In-Network.] 10.367

[After you have met your deductible, benefits for the Inpatient treatment of Mental Illness for those illnesses not classified as Serious Mental Illness and Inpatient Substance Abuse Rehabilitation Treatment (in a program that has a written agreement with Blue Cross and Blue Shield) will be provided at [50–100]% of the Eligible Charge or at [50–100]% of the Maximum Allowance when you receive Covered Services Out-of-Network.] 10.368

When you receive Out-of-Network Covered Services for the Inpatient treatment of Mental Illness for those illnesses not classified as Serious Mental Illness or Substance Abuse Rehabilitation Treatment in a program that does not have a written agreement with Blue Cross and Blue Shield or in a Non-Plan Provider facility, benefits will be provided at 50% of the Eligible Charge after you have met your deductible.

[You are entitled to a maximum of [45–365] Inpatient Hospital days each benefit period for the Inpatient treatment of Serious Mental Illness.] 10.369

[You are entitled to a maximum of [5–365] Inpatient Hospital days each benefit period for the Inpatient treatment of Mental Illness for those illnesses not classified as Serious Mental Illness and a maximum of [5–365] Inpatient Hospital days each benefit period for Inpatient Substance Abuse Rehabilitation Treatment.] 10.369

For every two days of care in a Partial Hospitalization Treatment Program, one day is deducted from your Inpatient Hospital days for the treatment of Mental Illness.]]

[None of the charges for the Inpatient and/or Outpatient treatment of Mental Illness for those illnesses not classified as Serious Mental Illness or Substance Abuse Rehabilitation Treatment will be applied in satisfying your Out-of-Pocket Expense Limit as explained later in this Certificate.]

[Lifetime Maximum for Mental Illness and Substance Abuse Rehabilitation Treatment

Your benefits for the Inpatient and Outpatient treatment of Mental Illness for those illnesses not classified as Serious Mental Illness and Substance Abuse Rehabilitation Treatment are limited to a combined lifetime maximum of $[500–750,000]. However, the maximum amount that will be paid for Out-of-Network Inpatient and Outpatient treatment of Mental Illness for those illnesses not classified as Serious Mental Illness and Substance Abuse Rehabilitation Treatment is a combined lifetime maximum of $[500–750,000]. 10.3691

[A combined lifetime maximum of [10–1,000] Inpatient Hospital days will apply to benefits for Inpatient treatment of Mental Illness for those illnesses not classified as Serious Mental Illness and Substance Abuse Rehabilitation Treatment.] 10.3692

[A combined lifetime maximum of [10–1,000] Outpatient visits will apply to benefits for Outpatient treatment of Mental Illness for those illnesses not classified as Serious Mental Illness and Substance Abuse Rehabilitation Treatment.]] 10.3693

PAYMENT PROVISIONS

Lifetime Maximum

[The total maximum amount of benefits to which you are entitled under this Comprehensive Major Medical Program is $[250,000–10,000,000]. This is an individual maximum. There is no family maximum.]

[As you use your benefits, a certain amount will automatically be restored to your lifetime maximum each year. This amount will be $1,000 or the amount you have received in benefits that benefit period, whichever is less.] 10.441

[Your benefits are not subject to a lifetime maximum. The total dollar amount that will be available in benefits for you is unlimited.] 10.442 10.44

[OUT-OF-POCKET EXPENSE LIMIT

If, during one benefit period, your out-of-pocket expense (the amount remaining unpaid after benefits have been provided plus any prior deductible credit if applicable) equals $[100–20,000], any additional eligible Claims (except for those Covered Services specifically excluded below) during that benefit period will be paid in full up to the Eligible Charge or Usual and Customary Fee.

This $[100–20,000] may be reached by any combination of:

- [the Comprehensive Major Medical deductible] 10.451a

- the payments for which you are responsible after the Comprehensive Major Medical benefits have been provided
- [and any unreimbursed expenses incurred for Comprehensive Major Medical Covered Services within your prior contract's benefit period, if not completed.] 10.453a

The following expenses for Covered Services cannot be applied to the out-of-pocket expense limit and will not be paid at 100% of the Eligible Charge or Maximum Allowance when your out-of-pocket expense limit is reached:

- [the Comprehensive Major Medical deductible] 10.451b
- charges that exceed the Eligible Charge or Usual and Customary Fee
- charges for Covered Services which have a separate dollar maximum specifically mentioned in this Certificate
- [charges for Covered Services for treatment of Mental Illness for those illnesses not classified as Serious Mental Illness or Substance Abuse Rehabilitation Treatment] 10.455
- [charges for Outpatient prescription drugs] 10.452
- [Copayments resulting from non-compliance with the provisions of the Medical Services Advisory Program and/or the Blue Cross and Blue Shield Mental Health Unit] 10.454
- the Coinsurance resulting from Covered Services rendered by a Non-Plan Hospital or other Non-Plan Provider for Covered Services other than Emergency Accident Care, Emergency Medical Care and Inpatient treatment during the period of time when your condition is serious
- [and any unreimbursed expenses incurred for Comprehensive Major Medical Covered Services within your prior contract's benefit period, if not completed.]] 10.453b

[If you have Family Coverage and [2,3] members of your family have reached their out-of-pocket expense limit during one benefit period, then, for the remainder of that benefit period, all other family members will have their Major Medical benefits for Covered Services (except for those Covered Services specifically excluded above) provided at 100% of the Eligible Charge or Usual and Customary Fee.] 10.46a

[If you have Family Coverage and your expenses as described above equal $[200–60,000] during one benefit period, then, for the rest of the benefit period, all other family members will have benefits for eligible Covered Services (except for those Covered Services specifically excluded above) provided at 100% of the Eligible Charge or Usual and Customary Fee. A member may not apply more than the individual out-of-pocket expense limit toward this amount.] 10.46b

EXTENSION OF BENEFITS IN CASE OF TERMINATION

If you are an Inpatient at the time your coverage under this Certificate is terminated, benefits will be provided for, and limited to, the Covered Services of this Certificate which are rendered by and regularly charged for by a Hospital, Skilled Nursing Facility, Substance Abuse Treatment Facility, Partial Hospitalization Treatment Program or Coordinated Home Care Program. Benefits will be provided until you are discharged or until the end of your benefit period, whichever occurs first.

BENEFIT INFORMATION

Your employer has chosen a Blue Cross and Blue Shield Participating Provider Option benefit program for your Hospital and Physician benefits that provides you access to the BlueChoice network. This program of health care benefits is designed to provide you with economic incentives for receiving Covered Services In-Network.

As a participant in this benefit program, a directory of Providers participating in the BlueChoice network will be available to you. You can visit the Blue Cross and Blue Shield of Illinois Web site at *www.bcbsil.com* for a list of Participating Providers. While there may be changes in the network list from time to time, selection of Providers by Blue Cross and Blue Shield will continue to be based upon the range of services, geographic location and cost-effectiveness of care. Notice of changes in the network will be provided to your Group Administrator annually, or as required, to allow you to make selection within the network. However, you are urged to check with your Provider before undergoing treatment to make certain of its participation status. Although you can go to the Hospital or Professional Provider of your choice, benefits under this benefit program will be greater when you receive services In-Network.

This section of your Certificate tells you what services are covered and how much will be paid for each of these services.

Your benefits are subject to all of the terms and conditions of this Certificate.[Your benefits are also subject to the Preexisting Conditions waiting period.] Please refer to the DEFINITIONS, ELIGIBILITY and EXCLUSIONS sections of this Certificate for additional information regarding any limitations and/or special conditions pertaining to your benefits. 0.564

In addition, the benefits for the Covered Services described in this section will be provided only when you receive services on or after your Coverage Date and they are rendered upon the direction or under the direct care of your Physician. Such services must be Medically Necessary and regularly included in the Provider's charges.

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

Before reading the description of your benefits, you should understand the terms "Benefit Period" and "Deductible" as defined below.

YOUR BENEFIT PERIOD

Your benefit period is a period of one year which begins on [Month Day] of each year. When you first enroll under this coverage, your first benefit period begins on your Coverage Date, and ends on the first [Month Day] following that date. 35.20

YOUR DEDUCTIBLE

[Each benefit period you must satisfy[a $[100–20,000] deductible][the deductible amount(s) specified in the Benefit Highlights (an insert) of this Certificate]. In other words, after you have Claims for more than $[100–20,000] of Covered Services in a benefit period, your benefits will begin. This deductible will be referred to as the program deductible.] 35.01a 35.01a1 35.01a2

[Each benefit period you must satisfy[a $[100–20,000] deductible for Covered Services In-Network and a separate $[200–60,000] deductible for Covered Services Out-of-Network or from Non-Plan Provider(s)][the deductible amount(s) specified in the Benefit Highlights (an insert) of this Certificate for Covered Services]. In other words, after you have Claims for Covered Services for more than the deductible amount in a benefit period, your benefits will begin. This deductible will be referred to as the program deductible.] 35.01b 35.01b1 35.01b2

[Each benefit period you must satisfy[the deductible amount specified in the Benefit Highlights (an insert) of this Certificate][a $ [200–60,000]deductible]for Covered Services Out-of-Network. In other words, after you have Claims for Covered Services Out-of-Network for more than the specified dollar amount in a benefit period, your benefits will begin. This deductible will be referred to as the program deductible. This deductible does not apply to Covered Services In-Network.] 35.01c 35.01c1 35.01c2

[If you have Individual Coverage, each benefit period you must satisfy[a $[100–20,000] program deductible][the deductible amount specified in the Benefit Highlights (an insert) of this Certificate] before receiving benefits. After you have Claims for Covered Services in a benefit period which exceed this deductible amount, your benefits will begin.] 35.01d 35.01d1 35.01d2

[If you have Individual Coverage, each benefit period you must satisfy[a $[100–20,000] program deductible for Covered Services In-Network and a separate $[100–20,000] program deductible for Covered Services Out-of-Network] [the deductible amount(s) specified in the Benefit Highlights (an insert) of this Certificate for Covered Services] before receiving benefits.] After you have Claims for Covered Services in a benefit period which exceed this deductible amount, your benefits will begin.] 35.01e 35.01e1 35.01e2

[Expenses incurred by you for Covered Services In-Network which are applied toward the In-Network program deductible will also be applied toward the Out-of-Network program deductible.] 35.015

[Expenses incurred by you for Covered Services Out-of-Network which are applied toward the Out-of-Network program deductible will also be applied toward the In-Network program deductible.] 35.014

[In addition to your program deductible, each time you are admitted to a Hospital In-Network, you must satisfy a $[100–5,000] deductible.] 35.012

[Each time you are admitted to a Hospital Out-of-Network or a Non-Plan Hospital, you must satisfy a $[100–5,000] deductible. This deductible is in addition to your program deductible.] 35.011

[If you have any expenses for Covered Services during the last three months of a benefit period which were or could have been applied to that benefit period's program deductible, these expenses may be applied toward the program deductible of the next benefit period.] 35.013

[If you have Family Coverage and [2,3] members of your family have each satisfied their program deductible, it will not be necessary for anyone else in your family to meet a program deductible in that benefit period. That is, for the remainder of that benefit period, no other family members are required to meet the program deductible before receiving benefits.] 35.02a

[If you have Family Coverage and your family has reached the program deductible [amount of $[100–20,000] for Covered Services In-Network and a separate $[200–60,000] program deductible for Covered Services Out-of-Network or from Non-Plan Provider(s)][amount(s) specified in the Benefit Highlights (an insert) of this Certificate for Covered Services], it will not be necessary for anyone else in your family to meet the program deductible in that benefit period. That is, for the remainder of that benefit period only, no other family member is required to meet the program deductible before receiving benefits. A family member may not apply more than the individual deductible amount toward the family deductible.] 35.02b 35.02b1 35.02b2

[If you have Family Coverage and your family has satisfied the family deductible amount [of $[100–20,000]][specified in the Benefit Highlights (an insert) of this Certificate], it will not be necessary for anyone else in your family to meet a program deductible in that benefit period. That is, for the remainder of that benefit period, no other family members will be required to meet the program deductible before receiving benefits. No one is eligible for benefits under Family Coverage until the entire family deductible amount has been satisfied.] 35.02c 35.02c1 35.02c2

[**The deductible amount may be adjusted based on the cost-of-living adjustment determined under the Internal Revenue Code and rounded to the nearest $50.**] 35.02c

[If you have Family Coverage and your family has reached the program deductible amount [of $[100–20,000]][specified in the Benefit Highlights (an insert) of this Certificate], it will not be necessary for anyone else in your family to meet a program deductible in that benefit period. That is, for the remainder of that benefit period, no other family members are required to meet a program deductible before receiving benefits. A family member may not apply more than the individual program deductible amount toward the family program deductible.] 35.02d 35.02d1 35.02d2

[If you have Family Coverage and your family has reached the program deductible amount [of $[100–20,000]][specified in the Benefit Highlights (an insert) of this Certificate] for Covered Services Out-of-Network or from Non-Plan Provider(s), it will not be necessary for anyone else in your family to meet a program deductible in that benefit period. That is, for the remainder of that benefit period, no other family members are required to meet a program deductible before receiving benefits. A family member may not apply more than the individual program deductible amount toward the family program deductible. This deductible does not apply to Covered Services In-Network.] 35.02e 35.02e1 35.02e2

[If you have Family Coverage and your family has satisfied the family deductible [amount of $[100–20,000] for Covered Services In-Network and a separate $[200–60,000] family deductible for Covered Services rendered Out-of-Network or by Non-Plan Provider(s)][amount(s) specified in the Benefit Highlights (an insert) of this Certificate for Covered Services], it will not be necessary for anyone else in your family to meet a program deductible in that benefit period. That is, for the remainder of that benefit period only, no other family member(s) will be required to meet the program deductible before receiving benefits. No one is eligible for benefits under Family Coverage until the entire family deductible amount has been satisfied.] 35.02f 35.02f1 35.02f2

[**The deductible amount may be adjusted based on the cost-of-living adjustment determined under the Internal Revenue Code and rounded to the nearest $50.**] 35.02f

[If you have Family Coverage and your family has satisfied the family deductible amount [of $[100–20,000]][specified in the Benefit Highlights (an insert) of this Certificate], it will not be necessary for anyone else in your family to meet a benefit program deductible in that benefit period. That is, for the remainder of that benefit period, no other family members will be required to meet the benefit program deductible before receiving benefits.] 35.02g 35.02g1 35.02g2

[**The deductible amount may be adjusted based on the cost-of-living adjustment determined under the Internal Revenue Code and rounded to the nearest $50.**] 35.02g

[If you have Family Coverage and your family has satisfied the family deductible [amount of $[100–20,000] for Covered Services In-Network and a separate $[200–60,000] family deductible for Covered Services Out-of-Network or from Non-Plan Provider(s)][amount(s) specified in the Benefit Highlights (an insert) of this Certificate for Covered Services], it will not be necessary for anyone else in your family to meet a benefit program deductible in that benefit period. That is, for the remainder of that benefit period only, no other family member(s) will be required to meet the benefit program deductible before receiving benefits.] 35.02h 35.02h1 35.02h2

[**The deductible amount may be adjusted based on the cost-of-living adjustment determined under the Internal Revenue Code and rounded to the nearest $50.**] 35.02h

[In any case, should two or more members of your family ever receive Covered Services as a result of injuries received in the same accident, only one program deductible will be applied against those Covered Services.] 35.021

[When your Group initially purchased this coverage, if you were a member of the Group at that time you are entitled to a special credit toward your [In-Network]program deductible for the first benefit period. This special credit applies to eligible expenses incurred for Covered Services within the prior contract's benefit period, if not completed. Such expenses can be applied toward the [In-Network]program deductible for the first benefit period under this coverage. However, this is only true if your Group had "major medical" type coverage immediately prior to purchasing this coverage.] 35.03

HOSPITAL BENEFIT SECTION

INPATIENT CARE

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

Inpatient Covered Services

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

Preadmission Testing

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

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

Partial Hospitalization Treatment Program

Benefits are available for this program only if it is a Blue Cross and Blue Shield approved program. No benefits will be provided for services rendered in a Partial Hospitalization Treatment Program which has not been approved by Blue Cross and Blue Shield.

[Benefits for Covered Services received in a Partial Hospitalization Treatment Program will be provided at the payment level specified for Inpatient treatment of Mental Illness and Inpatient Substance Abuse Rehabilitation Treatment in the SPECIAL CONDITIONS AND PAYMENT section of this Certificate.] 35.68b

Coordinated Home Care Program

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

[Each time you are admitted to a Coordinated Home Care Program, you are entitled to benefits for [5–365] visits.] 35.60a

[You are entitled to benefits for [5–365] visits in a Coordinated Home Care Program per benefit period.] 35.60b

[Your benefits for Coordinated Home Care are combined with your benefits for [Skilled Nursing Facility Care][and][Private Duty Nursing Service]. The maximum amount of benefits that will be provided for Coordinated Home Care[, Skilled Nursing Facility Care][and Private Duty Nursing Service] is a combined maximum of $[500–100,000] per benefit period.] 35.60c

BENEFIT PAYMENT FOR INPATIENT HOSPITAL COVERED SERVICES

In-Network

[Benefits will be provided at [50–100]% of the Hospital's Eligible Charge[after you have met your program deductible][and your Inpatient Hospital admission deductible] when you receive Inpatient Covered Services In-Network or in a Coordinated Home Care Program In-Network. If you are in a private room, benefits will be limited by the Hospital's rate for its most common type of room with two or more beds.] 35.012 35.11a

[When you receive Inpatient Covered Services In-Network or in a Coordinated Home Care Program In-Network, benefits will be provided at the In-Network Inpatient Hospital payment level specified in the Benefit Highlights (an insert) of this Certificate[after you have met your program deductible][and your Inpatient Hospital admission deductible]. If you are in a private room, benefits will be limited by the Hospital's rate for its most common type of room with two or more beds.] 35.012 35.11b

Out-of-Network

[When you receive Inpatient Covered Services Out-of-Network, benefits will be provided at [50–100]% of the Eligible Charge, after you have met your program deductible[and your Inpatient Hospital admission deductible]. If you are in a private room, benefits will be limited by the Hospital's rate for its most common type of room with two or more beds.] 35.011 35.12a

[When you receive Inpatient Covered Services Out-of-Network, benefits will be provided at the Out-of Network Inpatient Hospital payment level specified in the Benefit Highlights (an insert) of this Certificate after you have met your program deductible[and your Inpatient Hospital admission deductible]. If you are in a private room, benefits will be limited by the Hospital's rate for its most common type of room with two or more beds.] 35.011 35.12b

Non-Plan Provider

When you receive Inpatient Covered Services from a Non-Plan Provider, benefits will be provided at 50% of the Eligible Charge after you have met your program deductible[and your Inpatient Hospital admission deductible]. 35.011 35.13a

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

Benefits for an Inpatient Hospital admission Out-of-Network or to a Non-Plan Hospital resulting from Emergency Accident Care or Emergency Medical Care will be provided at the Out-of-Network Hospital payment level or the Non-Plan Hospital payment level (depending on the type of Provider) for that portion of your Inpatient Hospital stay during which your condition is reasonably determined by Blue Cross

and Blue Shield as not being serious and therefore permitting your safe transfer to a Hospital In-Network or other Provider In-Network.

In order for you to continue to receive benefits at the In-Network payment level following an emergency admission Out-of-Network or to a Non-Plan Hospital, you must transfer In-Network as soon as your condition is no longer serious.] 35.13a

[When you receive Inpatient Covered Services from a Non-Plan Provider, benefits will be provided at the same benefit payment level which would have been paid had such services been received Out-of-Network.] 35.13b

OUTPATIENT HOSPITAL CARE

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

Outpatient Hospital Covered Services

1. Surgery and any related Diagnostic Service received on the same day as the Surgery
2. Radiation Therapy Treatments
3. Chemotherapy
4. Electroconvulsive Therapy
5. Renal Dialysis Treatments—if received in a Hospital, a Dialysis Facility or in your home under the supervision of a Hospital or Dialysis Facility
6. Diagnostic Service—when you are an Outpatient and these services are related to Surgery or Medical Care
7. Emergency Accident Care—treatment must occur within 72 hours of the accident or as soon as reasonably possible.
8. Emergency Medical Care
9. Mammograms[—Benefits for routine mammograms will be provided at the benefit payment level described in the SPECIAL CONDITIONS AND PAYMENTS section of this Certificate. Benefits for mammograms, other than routine, will be provided at the same payment level as Outpatient Diagnostic Service.] 35.56 **Revised**
10. Pap Smear Test—Benefits will be provided for an annual routine cervical smear or Pap smear test for females[at the benefit payment level described in the Wellness Care provision of this Certificate]. 35.56
11. Prostate Test and Digital Rectal Examination—Benefits will be provided for an annual routine prostate-specific antigen test and digital rectal examination for males[at the benefit payment level described in the Wellness Care provision of this Certificate]. 35.56
12. Ovarian Cancer Screening—Benefits will be provided for annual ovarian cancer screening for females using CA-125 serum tumor marker testing, transvaginal ultrasound, and pelvic examination[at the benefit payment level described in the Wellness Care provision of this Certificate]. 35.56

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

    [Benefits for colorectal cancer screening will be provided at the benefit payment level described in the Wellness Care provision of this Certificate. Benefits for surgical procedures, such as colonoscopy and sigmoidoscopy, are not provided at the Wellness Care payment level. Such procedures will be provided at the benefit payment level for Surgery described in this Certificate.] 35.56

    [Benefits for colorectal cancer screening, including routine colonoscopy and sigmoidoscopy, will be provided at the benefit payment level described in the Wellness Care provision of this Certificate.] **New 9/09**

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

BENEFIT PAYMENT FOR OUTPATIENT HOSPITAL COVERED SERVICES

In-Network

[Benefits will be provided at [50–100]% of the Eligible Charge [after you have met your program deductible]when you receive Outpatient Hospital Covered Services In-Network.] 35.14a

[When you receive Outpatient Hospital Covered Services In-Network, benefits will be provided at the In-Network Outpatient Hospital payment level specified in the Benefit Highlights (an insert) of this Certificate[after you have met your program deductible].] 35.14b

[Benefits for Outpatient Surgery In-Network will be provided at [50–100]% of the Hospital's Eligible Charge[after you have met your program deductible].] 35.16 35.16a1

[Benefits for Outpatient Surgery will not be subject to the program deductible.] 35.16b1

[Benefits for Outpatient Diagnostic Service and mammograms (other than routine mammograms) In-Network will be provided at [50–100]% of the Hospital's Eligible Charge[after you have met your program deductible][and will not be subject to the program deductible].] Benefits for routine mammograms will be provided at the benefit payment level described in the SPECIAL CONDITIONS AND PAYMENTS section of this Certificate. 35.19 35.19a1 **Revised**

[Benefits for routine diagnostic tests (other than routine mammograms) In-Network will be provided at [50–100]% of the Hospital's Eligible Charge and will not be subject to the program deductible. Benefits for routine mammograms will be provided at the benefit payment level described in the SPECIAL CONDITIONS AND PAYMENTS section of this Certificate.] 35.191 **Revised**

Out-of-Network

[When you receive Outpatient Hospital Covered Services Out-of-Network, benefits will be provided at [50–100]% of the Eligible Charge after you have met your program deductible.] 35.15a

[When you receive Outpatient Hospital Covered Services Out-of-Network, benefits will be provided at the Out-of-Network Outpatient Hospital payment level specified in the Benefit Highlights (an insert) of this Certificate after you have met your program deductible.] 35.15b

[Benefits for Outpatient Surgery Out-of-Network will be provided at [50–100]% of the Hospital's Eligible Charge[after you have met your program deductible].] 35.16 35.16a2

[Benefits for Outpatient Surgery will not be subject to the program deductible.] 35.16b2

[Benefits for Outpatient Diagnostic Service and mammograms (other than routine mammograms) Out-of-Network will be provided at [50–100]% of the Hospital's Eligible Charge[after you have met your program deductible][and will not be subject to the program deductible]. Benefits for routine mammograms will be provided at the benefit payment level described in the SPECIAL CONDITIONS AND PAYMENTS section of this Certificate.] 35.19 35.19a2 **Revised**

Non-Plan Provider

[When you receive Outpatient Hospital Covered Services from a Non-Plan Provider, benefits will be provided at 50% of the Eligible Charge after you have met your program deductible. Covered Services received for Emergency Accident Care and Emergency Medical Care from a Non-Plan Provider will be paid at the same payment level which would have been paid had such services been received from a Provider In-Network.] 35.141a

[When you receive Outpatient Hospital Covered Services from a Non-Plan Provider, benefits will be provided at the same payment level which would have been paid had such services been received from a Provider Out-of-Network.] 35.141b

[**Emergency Care**

[Benefits for Emergency Accident Care will be provided at [50–100]% of the Eligible Charge when you receive Covered Services either In-Network, Out-of-Network or from a Non-Plan Provider.] 35.17a

[Benefits for Emergency Accident Care will be subject to the [In-Network]program deductible.] 35.171a1 35.171a11

[Benefits for Emergency Accident Care will not be subject to the program deductible.] 35.171a2

[Benefits for Emergency Medical Care will be provided at [50–100]% of the Eligible Charge when you receive Covered Services either In-Network, Out-of-Network or from a Non-Plan Provider.] 35.17b

[Benefits for Emergency Medical Care will be subject to the [In-Network]program deductible.] 35.171b1 35.171a12

[Benefits for Emergency Medical Care will not be subject to the program deductible.] 35.171b2

[Each time you receive Covered Services in an emergency room, you will be responsible for a Copayment of $[5–500]. If you are admitted to the Hospital as an Inpatient immediately following emergency treatment, the emergency room Copayment will be waived.] 35.172

[Each time you receive Covered Services in an emergency room, you will be responsible for the emergency room Copayment specified in the Benefit Highlights (an insert) of this Certificate.] 35.173

[However, Emergency Medical Care Covered Services received for the examination and testing of a victim of criminal sexual assault or abuse to determine whether sexual contact occurred, and to establish the presence or absence of sexually transmitted disease or infection, will be paid at 100% of the Eligible Charge whether or not you have met your program deductible.[The emergency room Copayment will not apply.]] 35.18a 35.181

[However, Covered Services received for Emergency Accident Care and Emergency Medical Care resulting from criminal sexual assault or abuse will be paid at 100% of the Eligible Charge whether or not you have met your program deductible.[The emergency room Copayment will not apply.]]] 35.18b 35.181

[Outpatient Surgery, Outpatient Diagnostic Service and Mammograms

[Outpatient Surgery,]Outpatient Diagnostic Service and mammograms (other than routine mammograms) are not subject to your program deductible and benefits will be provided at the payment levels specified for [Outpatient Surgery and]Outpatient Diagnostic Service in the Benefit Highlights (an insert) of this Certificate. Benefits for routine mammograms will be provided at the benefit payment level described in the SPECIAL CONDITIONS AND PAYMENTS section of this Certificate.] **Revised**

[Benefits for routine diagnostic tests (other than routine mammograms) In-Network will be provided at [50–100]% of the Hospital's Eligible Charge and will not be subject to the program deductible. Benefits for routine mammograms will be provided at the benefit payment level described in the SPECIAL CONDITIONS AND PAYMENT section of this Certificate.] 35.16c1 **Revised**

When you receive Outpatient Surgery, Outpatient Diagnostic Service and mammograms from a Non-Plan Provider, benefits will be provided at 50% of the Eligible Charge.] 35.16c

WHEN SERVICES ARE NOT AVAILABLE IN-NETWORK (HOSPITAL)

If you must receive Hospital Covered Services which Blue Cross and Blue Shield has reasonably determined are unavailable from a Provider In-Network, benefits for the Covered Services you receive from a Provider Out-of-Network will be provided at the payment level described for a Provider In-Network.

PHYSICIAN BENEFIT SECTION

This section of your Certificate tells you what services are covered and how much will be paid when you receive care from a Physician or other specified Professional Provider.

COVERED SERVICES

Surgery

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

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

The following services are also part of your surgical benefits:

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

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

2. Assist at Surgery—when performed by a Physician, Dentist or Podiatrist who assists the operating surgeon in performing covered Surgery in a Hospital or Ambulatory Surgical Facility. In addition, benefits will be provided for assist at Surgery when performed by [a Registered Surgical Assistant or]an Advanced Practice Nurse. Benefits will also be provided for assist at Surgery when performed by a Physician Assistant under the direct supervision of a Physician, Dentist or Podiatrist.[
3. Sterilization Procedures[(even if they are elective)].] 35.73

Additional Surgical Opinion

Your coverage includes benefits for an additional surgical opinion following a recommendation for elective Surgery. Your benefits will be limited to one consultation and related Diagnostic Service by a Physician.[Benefits for an additional surgical opinion consultation and related Diagnostic Service will be provided at 100% of the Claim Charge.][Your program deductible will not apply to this benefit.] If you request, benefits will be provided for an additional consultation when the need for Surgery, in your opinion, is not resolved by the first arranged consultation. 35.29a 35.29b

Medical Care

Benefits are available for Medical Care visits when:

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

[No benefits are available under this Benefit Section for the treatment of Mental Illness for those illnesses not classified as Serious Mental Illness or Outpatient Substance Abuse Rehabilitation Treatment. In addition, the treatment of Mental Illness and Substance Abuse Rehabilitation Treatment are subject to the maximums specified in the SPECIAL CONDITIONS AND PAYMENTS section of this Certificate.] 35.68a

[Your benefits for the Inpatient and Outpatient treatment of Mental Illness and Substance Abuse Rehabilitation Treatment will be provided as described in the SPECIAL CONDITIONS AND PAYMENTS section of this Certificate. However, benefits for the Inpatient treatment of Substance Abuse (i.e. detoxification and/or treatment of medical complications of Substance Abuse) will be provided as specified in the Benefit Payment for Physician Services provision of this Benefit Section.] 35.68b

Consultations

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

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 for such health care professionals will be provided at the Benefit Payment for Other Covered Services described in the OTHER COVERED SERVICES section of this Certificate. Benefits for Physicians will be provided at the Benefit Payment for Physician Services described later in this benefit section.

Benefits are also available for regular foot care examinations by a Physician or Podiatrist.

[**Well Child Care**

Benefits will be provided for Covered Services provided by a Physician to children under age [one–21], even though they are not ill. Benefits will be limited to the following services:

1. immunizations[for children under age [one–21]]; 35.552
2. physical examinations;
3. routine diagnostic tests. 35.55

[Benefits for well child care will be limited to a maximum of $[100–5,000] per benefit period[when you receive Covered Services Out-of-Network.]] 35.551 35.551a

[**Nutritional Counseling**—Benefits will be provided for nutritional counseling[, limited to a maximum of [$[100–5,000]][[one–18] visits] per benefit period].] **New**

Allergy Injections and Allergy Testing

Chemotherapy

Occupational Therapy

[Benefits will be provided for Occupational Therapy when these services are rendered by a registered Occupational Therapist under the supervision of a Physician. This therapy must be furnished under a written plan established by a Physician and regularly reviewed by the therapist and Physician. The plan must be established before treatment is begun and must relate to the type, amount, frequency and duration of therapy and indicate the diagnosis and anticipated goals.[Benefits for Outpatient Occupational Therapy[Out-of-Network] will be limited to a maximum of [$[1,000–30,000]][[5–365] visits] per benefit period.][Your benefits for Occupational Therapy, Physical Therapy and Speech Therapy are limited to a combined maximum of [[20–365] visits][$[1,000–60,000] per benefit period.] [There is no benefit period maximum for Occupational Therapy In-Network.]] **Revised** 35.66 35.66a

Physical Therapy

[Benefits will be provided for Physical Therapy when rendered by a registered professional Physical Therapist under the supervision of a Physician. The therapy must be furnished under a written plan established by a Physician and regularly reviewed by the therapist and the Physician. The plan must be established before treatment is begun and must relate to the type, amount, frequency and duration of therapy and indicate the diagnosis and anticipated goals. Benefits will also be provided for preventive or Maintenance Physical Therapy when prescribed for persons affected by multiple sclerosis[, subject to the Outpatient Physical Therapy maximum].[Benefits for Outpatient Physical Therapy[Out-of-Network] will be limited to a maximum of [$[1,000–30,000]][[5–365] visits] per benefit period.][Your benefits for Occupational Therapy, Physical Therapy and Speech Therapy are limited to a combined maximum of [[20–365] visits][$[1,000–60,000] per benefit period.][There is no benefit period maximum for Physical Therapy In-Network.]] **Revised** 35.63 35.63a

Radiation Therapy Treatments

Electroconvulsive Therapy

Speech Therapy

Benefits will be provided for Speech Therapy when these services are rendered by a licensed Speech Therapist or Speech Therapist certified by the American Speech and Hearing Association. Inpatient Speech Therapy benefits will be provided only if Speech Therapy is not the only reason for admission.[Benefits for Outpatient Speech Therapy[Out-of-Network] will be limited to a maximum of [$[1,000–30,000]][[5–365] visits] per benefit period.][Your benefits for Occupational Therapy, Physical Therapy and Speech Therapy are limited to a combined maximum of [[20–365] visits][$[1,000–60,000] per benefit period. However, benefits will be provided for an additional 20[20–365] visits for Speech Therapy for the treatment of pervasive developmental disorders.][There is no benefit period maximum for Speech Therapy In-Network.] However, benefits will be provided for an additional [20–365] visits for Speech Therapy[Out-of-Network] for treatment of pervasive developmental disorders. **Revised** 35.67 35.67a

Clinical Breast Examinations—Benefits will be provided for clinical breast examinations when performed by a Physician, Advanced Practice Nurse or a Physician Assistant working under the direct supervision of a Physician.[Benefits for clinical breast examinations will be provided at the benefit payment level described in the Wellness Care provision of this Certificate.] **New**

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

Mammograms—[Benefits for routine mammograms will be provided at the benefit payment described in the Wellness Care provision of this Certificate. Benefits for mammograms, other than routine, will be provided at the same payment level as Outpatient Diagnostic Service.] 35.56

Pap Smear Test—Benefits will be provided for an annual routine cervical smear or Pap smear test for females[at the benefit payment level described in the Wellness Care provision of this Certificate]. 35.56

Human Papillomavirus Vaccine—Benefits will be provided for a human papillomavirus (HPV) vaccine approved by the federal Food and Drug Administration.[Benefits will be provided at the benefit payment level for immunizations described in the Well Child Care provision of this Certificate for children under age [one–21].][Benefits will be provided at the benefit payment level for immunizations described in the Wellness Care provision of this Certificate[for persons age [one–21] and over].][Benefits will be provided at the benefit payment level for immunizations described in either the Wellness Care provision or the Well Child Care provision of this Certificate, whichever applies to you.] If you purchase the vaccine at a Pharmacy, benefits will be provided at the Benefit Payment for Other Covered Services described in the OTHER COVERED SERVICES section of this Certificate. [Benefits for the human papillomavirus vaccine are not subject to the well child care benefit maximum.]

New
35.HPVa
35.HPVb
35.HPVc

Shingles Vaccine—Benefits will be provided for a shingles vaccine approved by the federal Food and Drug Administration[at the benefit payment level described in the Wellness Care provision of this Certificate]. **New**

Prostate Test and Digital Rectal Examination—Benefits will be provided for an annual routine prostate-specific antigen test and digital rectal examination for males[at the benefit payment level described in the Wellness Care provision of this Certificate]. 35.56

Ovarian Cancer Screening—Benefits will be provided for annual ovarian cancer screening for females using CA-125 serum tumor marker testing, transvaginal ultrasound, and pelvic examination[at the benefit payment level described in the Wellness Care provision of this Certificate]. 35.56

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

[Benefits for colorectal cancer screening will be provided at the benefit payment level described in the Wellness Care provision of this Certificate. Benefits for surgical procedures, such as colonoscopy and sigmoidoscopy, are not provided at the Wellness Care payment level. Such procedure will be provided at the benefit payment level for Surgery described in this Certificate.] 35.56

[Benefits for colorectal cancer screening, including routine colonoscopy and sigmoidoscopy, will be provided at the benefit payment level described in the Wellness Care provision of this Certificate.] **New 9/09**

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

Emergency Accident Care—Treatment must occur within 72 hours of the accident or as soon as reasonably possible.

Emergency Medical Care

Chiropractic and Osteopathic Manipulation

Benefits will be provided for manipulation or adjustment of osseous or articular structures, commonly referred to as chiropractic and osteopathic manipulation, when performed by a person licensed to perform such procedures.[Your benefits for chiropractic and osteopathic manipulation will be limited to a maximum of $[500–60,000] per benefit period.] 35.65

Benefits will be provided for manipulation or adjustment of osseous or articular structures, commonly referred to as chiropractic and osteopathic manipulation, when performed by a person licensed to perform such procedures.[Your benefits for chiro-

practic and osteopathic manipulation will be limited to a maximum of [$[500–60,000]][[5–365] visits] per benefit period.] **Revised** 35.65

[**Acupuncture**—Benefits will be provided for acupuncture[, limited to a maximum of [$[100–20,000]][[5–365] visits] per benefit period].] **New**

[**Durable Medical Equipment**

Benefits will be provided for such things as internal cardiac valves, internal pacemakers, mandibular reconstruction devices (not used primarily to support dental prosthesis), bone screws, bolts, nails, plates, and any other internal and permanent devices as reasonably approved by Blue Cross and Blue Shield. Benefits will also be provided for the rental (but not to exceed the total cost of equipment) or purchase of durable medical equipment required for temporary therapeutic use provided that this equipment is primarily and customarily used to serve a medical purpose.] 35.28

[**Leg, Back, Arm and Neck Braces**] No longer used

[**Prosthetic Appliances**

Benefits will be provided for prosthetic devices, special appliances and surgical implants when:

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

Benefits will also include adjustments, repair and replacements of covered prosthetic devices, special appliances and surgical implants when required because of wear or change in a patient's condition (excluding dental appliances [other than intra-oral devices used in connection with the treatment of Temporomandibular Joint Dysfunction and Related Disorders, subject to specific limitations applicable to Temporomandibular Joint Dysfunction and Related Disorders,]and replacement of cataract lenses when a prescription change is not required).] 35.54 35.282

[**Orthotic Devices**

Benefits will be provided for a supportive device for the body or a part of the body, head, neck or extremities, including but not limited to, leg, back, arm and neck braces. In addition, benefits will be provided for adjustments, repairs or replacement of the device because of a change in your physical condition, as Medically Necessary. However, benefits will not be provided for foot orthotics defined as any in-shoe device designed to support the structural components of the foot during weight-bearing activities.] **New**

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.

[No benefits will be provided for [abortions][or][surgical sterilization procedures].] 35.74

Amino Acid-Based Elemental Formulas—Benefits will be provided for amino acid-based elemental formulas for the diagnosis and treatment of eosinophilic disorders or short-bowel syndrome, when the prescribing Physician has issued a written order stating that the amino acid-based elemental formula is medically necessary. If you purchase the formula at a Pharmacy, benefits will be provided at the Benefit Payment for Other Covered Services described in the OTHER COVERED SERVICES section of this Certificate. **New 9/09**

[**Routine Vision Examination**—Benefits will be provided for [one, 2] routine vision examination[(s)][, limited to a maximum of [$[30–600]][per benefit period].] **New**

BENEFIT PAYMENT FOR PHYSICIAN SERVICES

The benefits provided by Blue Cross and Blue Shield and the expenses that are your responsibility for your Covered Services will depend on whether you receive services In-Network or Out-of-Network and whether services are provided by a Participating or Non-Participating Professional Provider. In most cases, your benefits will be greater when you receive services In-Network.

[Your benefits for the Inpatient and Outpatient treatment of Mental Illness and Substance Abuse Rehabilitation Treatment will be provided as described in the SPECIAL CONDITIONS AND PAYMENTS section of this Certificate.] 35.68b

In-Network

[Benefits will be provided at [50–100]% of the Maximum Allowance[after you have met your program deductible] when you receive any of the Covered Services described in this Physician Benefit Section from an In-Network Professional Provider or from a Dentist. Although Dentists are not In-Network Professional Providers, they will be treated as such for purposes of benefit payment made under this Certificate and may bill you for the difference between the Blue Cross and Blue Shield benefit payment and the Provider's charge to you.] 35.21

[When you receive any of the Covered Services described in this Physician Benefit Section from an In-Network Professional Provider or from a Dentist, benefits will be provided at the In-Network Professional Provider payment level for Surgical/Medical Covered Services specified in the Benefit Highlights (an insert) of this Certificate[after you have met your program deductible]. Although Dentists are not In-Network Professional Providers, they will be treated as such for purposes of benefit payment made under this Certificate and may bill you for the difference between the Blue Cross and Blue Shield benefit payment and the Provider's charge to you.] 35.2b

[When you receive Covered Services In-Network other than Surgery, therapy and certain Diagnostic Services in a Professional Provider's office, benefits will be provided at [50–100]% of the Maximum Allowance and are subject to a Copayment of $[5–100] per visit. Such Diagnostic Services include MRI, CT Scan, [EKG, EEG, ECG,]pulmonary function studies, cardiac catheterization, and swan ganz catheterization.] 35.211a 35.211a1

[When you receive Covered Services In-Network in a Professional Provider's office, benefits for office visits are subject to[a Copayment of $[5–100] per visit][the Physi-

cian's office Copayment amount specified in the Benefit Highlights (an insert) of this Certificate]. Benefits for office visits will be provided at [50–100]% of the Maximum Allowance.]	35.211b 35.211b1 35.211b2
[When you receive Covered Services other than allergy injections and allergy surveys, Surgery, therapy and certain Diagnostic Services In-Network in a Professional Provider's office, benefits will be provided at [50–100]% of the Maximum Allowance and are subject to a Copayment of $[5–100] per visit. Such Diagnostic Services include MRI, CT Scan, [EKG, EEG, ECG,]pulmonary function studies, cardiac catheterization, and swan ganz catheterization.]	35.211c 35.211c1
[When you receive Covered Services other than allergy injections and allergy surveys, Surgery, therapy and certain Diagnostic Services In-Network in a Professional Provider's office, benefits will be provided at [50–100]% of the Maximum Allowance and are subject to the Physician office Copayment specified in the Benefit Highlights (an insert) of this Certificate. Such Diagnostic Services include MRI, CT Scan, [EKG, EEG, ECG,]pulmonary function studies, cardiac catheterization, and swan ganz catheterization.]	35.211d 35.211d1
[When you receive Covered Services for well child care In-Network, benefits will be provided at [50–100]% of the Maximum Allowance[subject to the Physician office visit Copayment].]	35.212
[Benefits for well child care In-Network will be subject to the program deductible.]	35.212a
[Benefits for well child care In-Network will not be subject to the program deductible.]	35.212b
[Benefits for chiropractic and osteopathic manipulations In-Network will be provided at [50–100]% of the Maximum Allowance[subject to the Physician office visit Copayment].]	35.213
[Benefits for chiropractic and osteopathic manipulations In-Network will be subject to the program deductible.]	35.213a
[Benefits for chiropractic and osteopathic manipulations In-Network will not be subject to the program deductible.]	35.213b
[Benefits for Outpatient Surgery In-Network will be provided at [50–100]% of the Maximum Allowance[after you have met your program deductible].]	35.26 35.26a
[Benefits for Outpatient Surgery In-Network will not be subject to the program deductible.]	35.26b
[Benefits for Outpatient Diagnostic Service and mammograms (other than routine mammograms) will be provided at [50–100]% of the Maximum Allowance from an In-Network Professional Provider[after you have met your program deductible][and will not be subject to the program deductible]. Benefits for routine mammograms will be provided at the benefit payment level described in the SPECIAL CONDITIONS AND PAYMENTS section of this Certificate.]	**Revised**
[Benefits for Outpatient Diagnostic Service and mammograms In-Network will not be subject to the program deductible.]	obsolete

[Benefits for routine vision examinations by an In-Network Professional Provider will be provided at [50–100]% of the Maximum Allowance[after you have met your program deductible].][Your program deductible will not apply.] **New**

Out-of-Network

[When you receive any of the Covered Services described in this Physician Benefit Section from a Professional Provider Out-of-Network, benefits will be provided at [50–100]% of the Maximum Allowance, after you have met your program deductible[, unless specifically mentioned below].] 35.22a

[Benefits for well child care Out-of-Network will be provided at [50–100]% of the Maximum Allowance[, after you have met your program deductible][and will not be subject to your program deductible].] 35.22a1 35.22a11 35.22a12

[Benefits for chiropractic and osteopathic manipulations Out-of-Network will be provided at [50–100]% of the Maximum Allowance[, after you have met your program deductible][and will not be subject to your program deductible].] 35.22a2 35.22a22 35.22a23

[When you receive any of the Covered Services described in this Physician Benefit Section from a Professional Provider Out-of-Network, benefits will be provided at the Out-of-Network Provider payment level for Surgical/Medical Covered Services specified in the Benefit Highlights (an insert) of this Certificate[after you have met your program deductible].] 35.2b

[When you receive Covered Services Out-of-Network other than Surgery, therapy and certain Diagnostic Services in a Professional Provider's office, benefits will be provided at [50–100]% of the Maximum Allowance and are subject to a Copayment of $[5–100] per visit. Such Diagnostic Services include MRI, CT Scan, [EKG, EEG, ECG,]pulmonary function studies, cardiac catheterization, and swan ganz catheterization.] 35.222a 35.222a1

[When you receive Covered Services Out-of-Network in a Professional Provider's office, benefits for office visits are subject to[a Copayment of $[5–100] per visit][the Physician's office Copayment amount specified in the Benefit Highlights (an insert) of this Certificate]. Benefits for office visits will be provided at [50–100]% of the Maximum Allowance.] 35.222b 35.222b1 35.222b2

[Benefits for Outpatient Surgery Out-of-Network will be provided at [50–100]% of the Maximum Allowance[after you have met your program deductible].] 35.26 35.26a2

[Benefits for Outpatient Surgery Out-of-Network will not be subject to the program deductible.] 35.26b2

[Benefits for Outpatient Diagnostic Service and mammograms (other than routine mammograms) will be provided at [50–100]% of the Maximum Allowance from an In-Network Professional Provider[after you have met your program deductible][and will not be subject to the program deductible]. Benefits for routine mammograms will be provided at the benefit payment level described in the SPECIAL CONDITIONS AND PAYMENTS section of this Certificate.] **Revised**

[Benefits for routine vision examinations by an Out-of-Network Professional Provider will be provided at [50–100]% of the Maximum Allowance[after you have met your program deductible].][Your program deductible will not apply.] **New**

[**Chiropractic and Osteopathic Manipulations**

Benefits for chiropractic and osteopathic manipulations will be provided at [50–100]% of the Maximum Allowance, after you have met your program deductible when rendered In-Network or Out-of-Network.] 35.221

[**Emergency Care** 35.230

[Benefits for Emergency Accident Care will be provided at [50–100]% of the Maximum Allowance when rendered In-Network or Out-of-Network[after you have met your][In-Network][program deductible.][. Your program deductible will not apply.] 35.231 35.231a 35.231a1 35.231b

[Benefits for Emergency Medical Care will be provided at [50–100]% of the Maximum Allowance when rendered In-Network or Out-of-Network[after you have met your][In-Network][program deductible.][. Your program deductible will not apply.] 35.232 35.232a 35.232a1 35.232b

[However, Emergency Medical Care Covered Services for the examination and testing of a victim of criminal sexual assault or abuse to determine whether sexual contact occurred, and to establish the presence or absence of sexually transmitted disease or infection, will be paid at 100% of the Maximum Allowance whether or not you have met your program deductible.] 35.25a

[However, Covered Services received for Emergency Accident Care and Emergency Medical Care resulting from criminal sexual assault or abuse will be paid at 100% of the Maximum Allowance whether or not you have met your program deductible.]] 35.25b

Participating Professional Providers are:

- Physicians[
- Podiatrists]
- Psychologists[
- Certified Clinical Nurse Specialists]
- Certified Nurse-Midwives[
- Certified Nurse Practitioners]
- Certified Registered Nurse Anesthetists[
- Chiropractors]
- Clinical Laboratories
- Clinical Professional Counselors
- Clinical Social Workers[
- Durable Medical Equipment Providers][
- Home Infusion Therapy Providers]
- Marriage and Family Therapists
- Occupational Therapists[
- Optometrists][
- Orthotic Providers]

- Physical Therapists[
- Prosthetic Providers][
- Registered Surgical Assistants]
- Retail Health Clinics]
- Speech Therapists

who have signed an agreement with Blue Cross and Blue Shield to accept the Maximum Allowance as payment in full. Such Professional Providers have agreed not to bill you for Covered Services amounts in excess of the Maximum Allowance. Therefore, you will be responsible only for the difference between the Blue Cross and Blue Shield benefit payment and the Maximum Allowance for the particular Covered Service — that is, your program deductible, Copayment and Coinsurance amounts.

Non-Participating Professional Providers are:

- Physicians[
- Podiatrists]
- Psychologists
- Dentists[
- Certified Clinical Nurse Specialists]
- Certified Nurse-Midwives[
- Certified Nurse Practitioners]
- Certified Registered Nurse Anesthetists
- Chiropractors
- Clinical Laboratories
- Clinical Professional Counselors
- Clinical Social Workers[
- Durable Medical Equipment Providers][
- Home Infusion Therapy Providers]
- Marriage and Family Therapists
- Occupational Therapists[
- Optometrists][
- Orthotic Providers]
- Physical Therapists[
- Prosthetic Providers][
- Registered Surgical Assistants]
- Retail Health Clinics]
- Speech Therapists

- other Professional Providers

who have not signed an agreement with Blue Cross and Blue Shield to accept the Maximum Allowance as payment in full. Therefore, you are responsible to these Providers for the difference between the Blue Cross and Blue Shield benefit payment and such Provider's charge to you.

Should you wish to know the Maximum Allowance for a particular procedure or whether a particular Professional Provider is a Participating Professional Provider, contact your Group Administrator, your Professional Provider or Blue Cross and Blue Shield.

[Regarding the Schedule of Maximum Allowances, you should also understand the following:

> If two or more surgical procedures are related or performed in the same operative area and are performed by the same or different Physician, Dentist or Podiatrist during the same operation, benefits will be provided only for the procedure which has the larger Maximum Allowance.
>
> If two or more surgical procedures are related or are performed in the same operative area, and are performed on different dates by the same or a different Physician, Dentist or Podiatrist, benefits will be based upon the procedure which has the largest Maximum Allowance and 50% of the Maximum Allowance for the procedure which has the next largest allowance.
>
> Procedures performed for conditions resulting from the same accident or injury are considered related.
>
> If a surgical procedure is repeated during an Inpatient stay, the benefit payment will be based upon 50% of the Maximum Allowance for such repeat procedure and only one such repeat will be considered a Covered Service.]

OTHER COVERED SERVICES

OTHER COVERED SERVICES

This section of your Certificate describes ‘‘Other Covered Services’’ and the benefits that will be provided for them.

- Blood and blood components[
- Leg, back, arm and neck braces] — No longer used
- Private Duty Nursing Service—Benefits for Private Duty Nursing Service will be provided to you in your home only when the services are of such a nature that they cannot be provided by non-professional personnel and can only be provided by a licensed health care provider. No benefits will be provided when a nurse ordinarily resides in your home or is a member of your immediate family. Private Duty Nursing includes teaching and monitoring of complex care skills such as tracheotomy suctioning, medical equipment use and monitoring to home caregivers and is not intended to provide for long term supportive care. Benefits for Private Duty Nursing Service will not be provided due to the lack of willing or available non-professional personnel.[Your benefits for Private Duty Nursing Service are limited to a maximum of $[200–60,000] per [month][benefit period].] — 35.64 35.64a 35.64b

  [Your benefits for Private Duty Nursing are combined with your benefits for [Skilled Nursing Facility Care] and [Coordinated Home Care]. The maximum amount of benefits that will be provided for Private Duty Nursing and[Skilled Nursing Facility Care][Coordinated Home Care] is a combined maximum of $[500–100,000] per benefit period.] — 35.64c 35.64c1 35.64c2
- Ambulance Transportation—Benefits will not be provided for long distance trips or for use of an ambulance because it is more convenient than other transportation.
- Dental accident care—Dental services rendered by a Dentist or Physician which are required as the result of an accidental injury.
- Oxygen and its administration
- Medical and surgical dressings, supplies, casts and splints[
- Durable medical equipment—Benefits will be provided for such things as internal cardiac valves, internal pacemakers, mandibular reconstruction devices (not used primarily to support dental prosthesis), bone screws, bolts, nails, plates, and any other internal and permanent devices as reasonably approved by Blue Cross and Blue Shield. Benefits will also be provided for the rental (but not to exceed the total cost of equipment) or purchase of durable medical equipment required for temporary therapeutic use provided that this equipment is primarily and customarily used to serve a medical purpose.][— No longer used
- Prosthetic appliances—Benefits will be provided for prosthetic devices, special appliances and surgical implants when: — No longer used
  a. they are required to replace all or part of an organ or tissue of the human body, or

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

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

- Optometric services—Benefits will be provided for services which may be legally rendered by an Optometrist, provided that benefits would have been provided had such services been rendered by a Physician.] — No longer used
- [Outpatient drugs and medicines—All drugs and medicines, except [contraceptive drugs or]drugs used for cosmetic purposes (including, but not limited to, Retin-A/Tretinoin and Minoxidil/Rogaine) which require by law a written prescription and which are dispensed by a Pharmacy or Physician. In addition, your coverage includes benefits for insulin and insulin syringes even though a prescription may not be required by law.] — 35.311 / 35.31
- Naprapathic Service—Benefits will be provided for Naprapathic Services when rendered by a Naprapath.[Benefits for Naprapathic Services will be limited to a maximum of $[200–60,000] per benefit period.]
- Wigs—Benefits will be provided for wigs (also known as cranial prostheses) when your hair loss is due to Chemotherapy, radiation therapy or alopecia.[Benefits for wigs will be limited to a lifetime maximum of $[100–5,000] per benefit period.] — **New**

BENEFIT PAYMENT FOR OTHER COVERED SERVICES

[**After you have met your program deductible, benefits will be provided at [50–100]% of the Eligible Charge or [50–100]% of the Maximum Allowance for any of the Covered Services described in this section.[However, benefits for Outpatient drugs and medicines will be provided at [50–100]% of the Eligible Charge, after you have met your program deductible.]]** — 35.33a / 35.PD

[When you receive Other Covered Services either In-Network or Out-of-Network benefits for Other Covered Services will be provided at the payment levels previously described in this Certificate for Hospital and Physician Covered Services.] — **New**

The expenses that are your responsibility for your Other Covered Services will depend on whether you receive services In-Network or Out-of-Network and whether services are provided by a Participating or Non-Participating Professional Provider.

Participating Professional Providers are:

- Physicians[
- Podiatrists]
- Psychologists[
- Certified Clinical Nurse Specialists]

- Certified Nurse-Midwives[
- Certified Nurse Practitioners]
- Certified Registered Nurse Anesthetists[
- Chiropractors]
- Clinical Laboratories
- Clinical Professional Counselors
- Clinical Social Workers[
- Durable Medical Equipment Providers][
- Home Infusion Therapy Providers]
- Marriage and Family Therapists
- Occupational Therapists[
- Optometrists][
- Orthotic Providers]
- Physical Therapists[
- Prosthetic Providers][
- Registered Surgical Assistants]
- Retail Health Clinics]
- Speech Therapists

who have signed an agreement with Blue Cross and Blue Shield to accept the Maximum Allowance as payment in full. Such Professional Providers have agreed not to bill you for Covered Services amounts in excess of the Maximum Allowance. Therefore, you will be responsible only for the difference between the Blue Cross and Blue Shield benefit payment and the Maximum Allowance for the particular Covered Service — that is, your program deductible, Copayment and Coinsurance amounts.

Non-Participating Professional Providers are:

- Physicians
- Podiatrists
- Psychologists
- Dentists[
- Certified Clinical Nurse Specialists]
- Certified Nurse-Midwives[
- Certified Nurse Practitioners]
- Certified Registered Nurse Anesthetists
- Chiropractors
- Clinical Laboratories

- Clinical Professional Counselors
- Clinical Social Workers[
- Durable Medical Equipment Providers][
- Home Infusion Therapy Providers]
- Marriage and Family Therapists
- Occupational Therapists[
- Optometrists][35.281
- Orthotic Providers] 35.282
- Physical Therapists[
- Prosthetic Providers][35.282
- Registered Surgical Assistants] 35.282
- Retail Health Clinics]
- Speech Therapists
- other Professional Providers

who have not signed an agreement with Blue Cross and Blue Shield to accept the Maximum Allowance as payment in full. Therefore, you are responsible to these Providers for the difference between the Blue Cross and Blue Shield benefit payment and such Provider's charge to you.

Should you wish to know the Maximum Allowance for a particular procedure or whether a particular Professional Provider is a Participating Professional Provider, contact your Group Administrator, your Professional Provider or Blue Cross and Blue Shield.

SPECIAL CONDITIONS AND PAYMENTS

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

HUMAN ORGAN TRANSPLANTS

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

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

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

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

Benefits will be provided for:

— Inpatient and Outpatient Covered Services related to the transplant Surgery.

— the evaluation, preparation and delivery of the donor organ.

— the removal of the organ from the donor.

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

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

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

— [If 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 [30–200] miles from the Hospital where the transplant will be performed.] 35.72

- [You and your companion are each entitled to benefits for lodging and meals up to a combined maximum of $[100–5,000] per day.] 35.721a
- [You and your companion are each entitled to benefits for lodging up to a combined maximum of $[100–5,000] per day.] 35.721b
- [Benefits for transportation, lodging and meals are limited to a maximum of $[1,000–30,000] per transplant.] 35.722a
- [Benefits for transportation, lodging and meals are limited to a lifetime maximum of $[1,000–30,000].] 35.722b

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

- Cardiac rehabilitation services when not provided to the transplant recipient immediately following discharge from a Hospital for transplant Surgery.
- Travel time and related expenses required by a Provider.
- Drugs which do not have approval of the Food and Drug Administration.
- Storage fees.
- Services provided to any individual who is not the recipient or actual donor, unless otherwise specified in this provision.

[Your benefits for heart, lung, heart/lung, liver, pancreas and pancreas/kidney transplants are subject to a lifetime maximum of $[250,000–10,000,000]. This lifetime maximum is separate from your lifetime maximum for all other benefits.] 35.61

CARDIAC REHABILITATION SERVICES

Your benefits for cardiac rehabilitation services are the same as your benefits for any other condition. Benefits will be provided for cardiac rehabilitation services only in Blue Cross and Blue Shield approved programs. Benefits are available if you have a history of any of the following: acute myocardial infarction, coronary artery bypass graft Surgery, percutaneous transluminal coronary angioplasty, heart valve Surgery, heart transplantation, stable angina pectoris, compensated heart failure or transmyocardial revascularization. Benefits will be limited to a maximum of 36 Outpatient treatment sessions within the six month period.

[WELLNESS CARE

[Benefits will be provided for Covered Services rendered to persons age [one–21] and over, even though they are not ill. Benefits will be limited to the following services:] 35.56c

[Benefits will be provided for Covered Services rendered to children under age [one–21], even though they are not ill. Benefits will be limited to the following services:] 35.56a

[Benefits will be provided for Covered Services rendered to you, even though you are not ill. Benefits will be limited to the following services:] 35.56b

1. Immunizations[for children under age [one–21]]. 35.566

2. Routine physical examinations[– [one–4] per benefit period]. 35.567
3. [Routine gynecological examinations[– [one–4] per benefit period]. 35.5671 35.56711
4. [Routine vision examinations[– [one, 2] per benefit period];] **New**
5. Routine diagnostic tests[ordered or received on the same day as the examination]. 35.568
6. Routine diagnostic tests (other than routine mammograms),[ordered or received on the same day as the examination]. Benefits for routine mammograms will be provided at the benefit payment level described in the SPECIAL CONDITIONS AND PAYMENTS section of this Certificate. 35.568 **Revised**

In-Network

[Benefits for wellness care In-Network will be provided at [50–100]% of the Eligible Charge or [50–100]% of the Maximum Allowance[after you have met your program deductible][and will not be subject to the program deductible][when Covered Services are received from a Provider other than in a Physician's office].] 35.561 35.562

[When you receive Covered Services for wellness care In-Network [other than in a Physician's office], benefits for wellness care will be provided at the In-Network payment level for Hospital Outpatient Covered Services or Surgical/Medical Covered Services specified in the Benefit Highlights (an insert) of this Certificate [after you have met your program deductible][and will not be subject to the program deductible].] 35.561 35.562

[Benefits for routine diagnostic tests In-Network will be provided at [50–100]% of the Eligible Charge or Maximum Allowance and will not be subject to the program deductible or Copayment.] 35.569

[When you receive Covered Services other than certain diagnostic tests for wellness care In-Network in a Professional Provider's office, benefits for Covered Services will be provided at [50–100]% of the Maximum Allowance and are subject to a Copayment of $[5–100] per visit. Such diagnostic tests include MRI, CT Scan, [EKG, EEG, ECG]and pulmonary function studies.] 35.565a 35.565a1

[When you receive Covered Services In-Network in a Professional Provider's office, benefits for office visits are subject to[a Copayment of $[5–100] per visit][the Physician's office Copayment amount specified in the Benefit Highlights (an insert) of this Certificate].] 35.565b 35.565b1 35.565b2

[When you receive Covered Services for wellness care In-Network in a Professional Provider's office, benefits for Covered Services will be provided at [50–100]% of the Maximum Allowance and are subject to a Copayment of $[5–100] per visit.] 35.565c

[When you receive Covered Services for wellness care In-Network in a Professional Provider's office, benefits for Covered Services will be provided at [50–100]% of the Maximum Allowance and are subject to the Physician office Copayment specified in the Benefit Highlights (an insert) of this Certificate.] 35.565d

Out-of-Network

[Benefits for wellness care Out-of-Network will be provided at [50–100]% of the Eligible Charge or [50–100]% of the Maximum Allowance[after you have met your program deductible][and will not be subject to the program deductible].] 35.561OON 35.562OON

[Benefits for wellness care Out-of-Network will be provided at the Out-of-Network payment level for Hospital Outpatient Covered Services or Surgical/Medical Covered Services specified in the Benefit Highlights (an insert) of this Certificate [after you have met your program deductible][and will not be subject to the program deductible].] 35.561OON 35.562OON

[When you receive Covered Services other than certain diagnostic tests for wellness care Out-of-Network in a Professional Provider's office, benefits for Covered Services will be provided at [50–100]% of the Maximum Allowance and are subject to a Copayment of $[5–100] per visit. Such diagnostic tests include MRI, CT Scan, [EKG, EEG and ECG]and pulmonary function studies.] 35.563a 35.563a1

[When you receive Covered Services Out-of-Network in a Professional Provider's office, benefits for office visits are subject to[a Copayment of $[5–100] per visit][the Physician's office Copayment amount specified in the Benefit Highlights (an insert) of this Certificate].] 35.563b 35.563b1 35.563b2

[**Wellness Care Benefit Maximum**

[Benefits for wellness care will be limited to a maximum of $[100–5,000] per benefit period[when you receive Covered Services Out-of-Network].] 35.571 35.5711

[Benefits for wellness care will be limited to a maximum of $[100–5,000] per benefit period[when you receive Covered Services Out-of-Network].] 35.572 35.5721

[Benefits for wellness care will be limited to a maximum of $[100–5,000] per benefit period[when you receive Covered Services Out-of-Network].] 35.574 35.5741

[Benefits for wellness care will be limited to a benefit period maximum of $[100–5,000] for children under age [one–21] and $[100–5,000] for persons age [one–21] and over[when you receive Covered Services Out-of-Network].] 35.573 35.5731 35.5732 35.5733

[The following Covered Services are not subject to the wellness care benefit maximum: Pap smear test, prostate test and digital rectal examination, colorectal cancer screening, ovarian cancer screening, clinical breast examination, human papillomavirus vaccine and shingles vaccine.] 35.570 35.57 **Revised**

SKILLED NURSING FACILITY CARE

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

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

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.

[Benefits for Covered Services rendered in a Plan Skilled Nursing Facility will be provided at [50–100]% of the Eligible Charge[after you have met your program deductible].] 35.42a

[Benefit payment for Covered Services rendered by a Plan Skilled Nursing Facility will be provided at the same payment level as specified in the Benefit Highlights (an insert) of this Certificate for In-Network Hospital Inpatient Covered Services.] 35.42b

[Benefits for Covered Services rendered in a Non-Plan Skilled Nursing Facility will be provided at [50–100]% of the Eligible Charge, once you have met your program deductible. Benefits will not be provided for Covered Services received in an Uncertified Skilled Nursing Facility.] 35.431 35.43

[Each time you are admitted to a Skilled Nursing Facility, you are entitled to benefits for [5–365] days of care.] 35.421a

[You are entitled to benefits for [5–365] days of care in a Skilled Nursing Facility per benefit period.] 35.421b

[Your benefits for Skilled Nursing Facility Care are combined with your benefits for [Private Duty Nursing][and Coordinated Home Care]. The maximum amount of benefits that will be provided for Skilled Nursing Facility Care[, Private Duty Nursing][and Coordinated Home Care] is a combined maximum of $[500–100,000] per benefit period.] 35.421c 35.421c1 35.421c2

AMBULATORY SURGICAL FACILITY

Benefits for all of the Covered Services previously described in this Certificate are available for Outpatient Surgery. In addition, benefits will be provided if these services are rendered by an Ambulatory Surgical Facility.

[Benefits for services rendered by a Plan Ambulatory Surgical Facility will be provided at [50–100]% of the Eligible Charge. Benefits for services by a Non-Plan Ambulatory Surgical Facility will be provided at [50–100]% of the Eligible Charge.] 35.44a

[Benefit payment for Covered Services rendered by a Plan Ambulatory Surgical Facility will be provided at the same payment level as specified in the Benefit Highlights (an insert) of this Certificate for In-Network Hospital Outpatient Surgery. Benefits for services by a Non-Plan Ambulatory Surgical Facility will be provided at 50% of the Eligible Charge.] 35.44b

[Benefits for Outpatient Surgery will be provided as stated above whether or not you have met your program deductible.] 35.441

[Benefits for Outpatient Surgery will be provided as stated above after you have met your program deductible.] 35.442

ROUTINE MAMMOGRAMS **New**

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

— one baseline mammogram

— an annual mammogram]

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

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

In-Network

Benefits for routine mammograms when rendered by an In-Network Provider will be provided at 100% of the Eligible Charge or Maximum Allowance whether or not you have met your program deductible.[Benefits for routine mammograms In-Network will not be subject to the Physician office visit Copayment.]

Out-of-Network

Benefits for routine mammograms when rendered by an Out-of-Network Provider will be provided at [50–100]% of the Eligible Charge or [50–100]% of the Maximum Allowance[whether or not you have met your program deductible][after you have met your program deductible]].[Benefits for routine mammograms Out-of-Network will not be subject to the Physician office visit Copayment.]

[**Benefit Maximum**

[Benefits for routine mammograms will not be subject to any [benefit period maximum or]lifetime maximum.]

[SUBSTANCE ABUSE REHABILITATION TREATMENT]

[Benefits for all of the Covered Services described in this Certificate are available for Substance Abuse Rehabilitation Treatment. In addition, benefits will be provided if these Covered Services are rendered by a Substance Abuse Treatment Facility. Benefits will be provided at the payment levels described later in this benefit section. Substance Abuse Rehabilitation Treatment Covered Services rendered in a program that does not have a written agreement with Blue Cross and Blue Shield or in a Non-Plan Provider facility will be paid at the Non-Plan Provider facility payment level described later in this benefit section.]

[Your benefits for Substance Abuse Rehabilitation Treatment are the same as your benefits for any other condition. In addition, benefits will be provided if Covered Services are rendered by a Substance Abuse Treatment Facility. Substance Abuse Rehabilitation Treatment Covered Services rendered in a program that does not have a written agreement with Blue Cross and Blue Shield or in a Non-Plan Provider facility will be paid at the Non-Plan Provider facility payment level.]

[MENTAL ILLNESS SERVICES]

[Benefits for all of the Covered Services described in this Certificate are available for the diagnosis and/or treatment of a Mental Illness. Medical Care for the treatment of a Mental Illness is eligible when rendered by (1) a Physician; (2) a Psychologist; (3) a

Clinical Social Worker; (4) a Clinical Professional Counselor or (5) a Marriage and Family Therapist working within the scope of their license.]

[Your benefits for the diagnosis and/or treatment of a Mental Illness are the same as your benefits for any other condition. Medical Care for the treatment of a Mental Illness is eligible when rendered by (1) a Physician; (2) a Psychologist; (3) a Clinical Social Worker; (4) a Clinical Professional Counselor or (5) a Marriage and Family Therapist working within the scope of their license.]

[CHRONIC CONDITION MANAGEMENT

Benefits will be provided for services for the management of prescription drugs prescribed as part of psychiatric care, including the prescription, use and review of medication with no more than minimal medical psychotherapy.] 35.68b

[Benefit Payment for Outpatient treatment of Mental Illness and Substance Abuse Rehabilitation Treatment

Benefits for Outpatient treatment of Serious Mental Illness will be provided at the payment levels previously described in this Certificate for Hospital and Physician Covered Services.

[Benefits for Outpatient treatment of Mental Illness for those illnesses not classified as Serious Mental Illness will be provided at [[50–100]% of the Eligible Charge or at [50–100]% of the Maximum Allowance][the In-Network payment levels specified in the Benefit Highlights (an insert) of this Certificate][after you have met your program deductible]when you receive Covered Services In-Network.]

[When you receive Covered Services In-Network in a Professional Provider's office for the Outpatient treatment of Mental Illness, benefits for office visits are subject to a Copayment of $[5–100] per visit. Benefits for office visits will be provided at [50–100]% of the Maximum Allowance.] 35.46a1

When you receive Covered Services Out-of Network for Outpatient treatment of Mental Illness for those illnesses not classified as Serious Mental Illness, benefits will be provided at [50–100]% of the Eligible Charge or [50–100]% of the Maximum Allowance after you have met your program deductible.] 35.46a

[Benefits for Outpatient treatment of Mental Illness for those illnesses not classified as Serious Mental Illness will be provided at [50–100]% of the Eligible Charge or at [50–100]% of the Maximum Allowance for the first [5–365] visits per benefit period[after you have met your program deductible], thereafter benefits will be provided at 50% of the Eligible Charge or at 50% of the Maximum Allowance when you receive services In-Network.

[When you receive Covered Services In-Network in a Professional Provider's office for the Outpatient treatment of Mental Illness, benefits for office visits are subject to a Copayment of $[5–100] per visit. Benefits for office visits will be provided at [50–100]% of the Maximum Allowance.] 35.46b1

When you receive Covered Services Out-of-Network for Outpatient treatment of Mental Illness for those illnesses not classified as Serious Mental Illness, benefits will be provided at [50–100]% of the Eligible Charge or [50–100]% of the Maximum Allowance for the first [5–365] visits per benefit period after you have met your

deductible, thereafter benefits will be provided at 50% of the Eligible Charge or at 50% of the Maximum Allowance after you have met your program deductible.] 35.46b

[Benefits for Outpatient Substance Abuse Rehabilitation Treatment (in a program that has a written agreement with Blue Cross and Blue Shield) will be provided at [50–100]% of the Eligible Charge or at [50–100]% of the Maximum Allowance [after you have met your program deductible]when you receive services In-Network or from a Plan Provider facility.

[When you receive Covered Services In-Network in a Professional Provider's office for Outpatient Substance Abuse Rehabilitation Treatment, benefits for office visits are subject to a Copayment of $[5–100] per visit. Benefits for office visits will be provided at [50–100]% of the Maximum Allowance.] 35.47a1

When you receive Covered Services Out-of-Network for Outpatient Substance Abuse Rehabilitation Treatment (in a program that has a written agreement with Blue Cross and Blue Shield), benefits will be provided at [50–100]% of the Eligible Charge or[50–100] % of the Maximum Allowance after you have met your program deductible.] 35.47a

[Benefits for Outpatient Substance Abuse Rehabilitation Treatment (in a program that has a written agreement with Blue Cross and Blue Shield) will be provided at [50–100]% of the Eligible Charge or at [50–100]% of the Maximum Allowance for the first [5–365] visits per benefit period[after you have met your program deductible], thereafter benefits will be provided at 50% of the Eligible Charge or at 50% of the Maximum Allowance when you receive services In-Network or from a Plan Provider facility.

[When you receive Covered Services In-Network in a Professional Provider's office for Outpatient Substance Abuse Rehabilitation Treatment, benefits for office visits are subject to a Copayment of $[5–100] per visit. Benefits for office visits will be provided at [50–100]% of the Maximum Allowance.] 35.47b1

When you receive Covered Services Out-of-Network for Outpatient Substance Abuse Rehabilitation Treatment (in a program that has a written agreement with Blue Cross and Blue Shield), benefits will be provided at [50–100]% of the Eligible Charge or [50–100]% of the Maximum Allowance for the first [5–365] visits per benefit period after you have met your deductible, thereafter benefits will be provided at 50% of the Eligible Charge or at 50% of the Maximum Allowance.] 35.47b

[When you receive Covered Services for the Outpatient treatment of Mental Illness or Substance Abuse Rehabilitation Treatment in a program that does not have a written agreement with Blue Cross and Blue Shield or in a Non-Plan Provider facility, benefits will be provided at 50% of the Eligible Charge after you have met your program deductible.] 35.533a

[When you receive Covered Services for the Outpatient treatment of Mental Illness or Substance Abuse Rehabilitation Treatment in a program that does not have an agreement with Blue Cross and Blue Shield or in a Non-Plan Provider facility, benefits will be provided at the same payment level as Out-of-Network Hospital Covered Services.]] 35.533b

[Benefit Maximum for Outpatient treatment of Mental Illness and Substance Abuse Rehabilitation Treatment 35.471

[Your benefits for Outpatient treatment of Serious Mental Illness are limited to a maximum of [35–365] visits per benefit period.] 35.471d

[Your benefits for Outpatient treatment of Mental Illness for those illness not classified as Serious Mental Illness and Outpatient Substance Abuse Rehabilitation Treatment are limited to a combined maximum of [5–365] visits per benefit period.] 35.471b

[Your benefits for Outpatient treatment of Mental Illness for those illnesses not classified as Serious Mental Illness are limited to a maximum of [5–365] visits per benefit period.] 35.471c

[Your benefits for Outpatient Substance Abuse Rehabilitation Treatment are limited to a maximum of [5–365] visits per benefit period.] 35.471c1

Your benefits for Outpatient Substance Abuse Rehabilitation Treatment are limited to a maximum of $[500–100,000] per benefit period.]] 35.471c2

[Benefit Payment for Inpatient treatment of Mental Illness and Substance Abuse Rehabilitation Treatment

Benefits for the Inpatient treatment of Serious Mental Illness will be provided at the payment levels previously described in this Certificate for Hospital and Physician Covered Services.

[Benefits for the Inpatient treatment of Mental Illness for those illnesses not classified as Serious Mental Illness and Inpatient Substance Abuse Rehabilitation Treatment will be provided at the payment levels previously described in this Certificate for Hospital and Physician Covered Services.] 35.53a

[Benefits for the Inpatient treatment of Mental Illness for those illnesses not classified as Serious Mental Illness and Inpatient Substance Abuse Rehabilitation Treatment (in a program that has a written agreement with Blue Cross and Blue Shield) will be provided at [50–100]% of the Eligible Charge for the first [5–365] days of each admission[after your program deductible][and your Inpatient Hospital admission deductible], thereafter any remaining eligible Hospital charges will be paid at 50% of the Eligible Charge when you receive Covered Services In-Network.] 35.531a

[Benefits for the Inpatient treatment of Mental Illness for those illnesses not classified as Serious Mental Illness and Inpatient Substance Abuse Rehabilitation Treatment (in a program that has a written agreement with Blue Cross and Blue Shield) will be provided at [50–100]% of the Eligible Charge[after your program deductible] when you receive Covered Services In-Network.] 35.531b

[Benefits for the Inpatient treatment of Mental Illness for those illnesses not classified as Serious Mental Illness and Inpatient Substance Abuse Rehabilitation Treatment (in a program that has a written agreement with Blue Cross and Blue Shield) will be provided at [50–100]% of the Eligible Charge for the first [5–365] days of each admission after your program deductible[and your Inpatient Hospital admission deductible], thereafter any remaining eligible Hospital charges will be paid at 50% of the Eligible Charge when you receive Covered Services Out-of-Network.] 35.532a

[Benefits for the Inpatient treatment of Mental Illness for those illnesses not classified as Serious Mental Illness and Inpatient Substance Abuse Rehabilitation Treatment (in a program that has a written agreement with Blue Cross and Blue Shield) will be provided at [50–100]% of the Eligible Charge after you have met your program deductible[and your Inpatient Hospital admission deductible] when you receive Covered Services Out-of-Network.] 35.532b

[When you receive Covered Services for the Inpatient treatment of Mental Illness or Substance Abuse Rehabilitation Treatment in a program that does not have a written agreement with Blue Cross and Blue Shield or in a Non-Plan Provider facility, benefits will be provided at 50% of the Eligible Charge after you have met your program deductible and your Inpatient Hospital admission deductible.] 35.533a

[When you receive Covered Services for the Inpatient treatment of Mental Illness or Substance Abuse Rehabilitation Treatment in a program that does not have a written agreement with Blue Cross and Blue Shield or in a Non-Plan Provider facility, benefits will be provided at the same payment level as Out-of-Network Hospital Covered Services.] 35.533b

[When you receive Covered Services In-Network for the Inpatient treatment of Mental Illness for those illnesses not classified as Serious Mental Illness or Inpatient Substance Abuse Rehabilitation Treatment from a Professional Provider, benefits will be provided at [50–100]% of the Maximum Allowance[after you have met your program deductible]. 35.534

When you receive Covered Services Out-of-Network for the Inpatient treatment of Mental Illness for those illnesses not classified as Serious Mental Illness or Inpatient Substance Abuse Rehabilitation Treatment from a Professional Provider, benefits will be provided at [50–100]% of the Maximum Allowance after you have met your program deductible.]] 35.534 35.53b

[Benefit Maximum for Inpatient treatment of Mental Illness and Substance Abuse Rehabilitation Treatment

[You are entitled to a maximum of [45–365] Inpatient Hospital days each benefit period for Inpatient treatment of Serious Mental Illness.] 35.48d

[You are entitled to a combined maximum of [5–365] Inpatient Hospital days each benefit period for Inpatient treatment of Mental Illness for those illnesses not classified as Serious Mental Illness and Inpatient Substance Abuse Rehabilitation Treatment.] 35.48a

[You are entitled to a maximum of [5–365] Inpatient Hospital days each benefit period for Inpatient treatment of Mental Illness for those illnesses not classified as Serious Mental Illness.] 35.48b

[You are entitled to a maximum of [5–365] Inpatient Hospital days each benefit period for Inpatient Substance Abuse Rehabilitation Treatment.] 35.48b1

[Your benefits for Inpatient Substance Abuse Rehabilitation Treatment are limited to a maximum of $[500–750,000] each benefit period.]] 35.48b2

[Lifetime Benefit Maximum for treatment of Mental Illness and Substance Abuse Rehabilitation Treatment

[You are entitled to a combined lifetime maximum of [10–1,000] Inpatient Hospital days for Inpatient treatment of Mental Illness for those illnesses not classified as Serious Mental Illness and Substance Abuse Rehabilitation Treatment.] 35.491

[You are entitled to a lifetime maximum of [10–1,000] Inpatient Hospital days for Inpatient treatment of Mental Illness for those illnesses not classified as Serious Mental Illness.] 35.496

[You are entitled to a lifetime maximum of [10–1,000] Inpatient Hospital days for Inpatient Substance Abuse Rehabilitation Treatment.] 35.497a

[A lifetime maximum of $[500–750,000] will apply to benefits for Inpatient Substance Abuse Rehabilitation Treatment.] 35.497b

[You are entitled to a combined lifetime maximum of [10–1,000] Outpatient visits for Outpatient treatment of Mental Illness for those illnesses not classified as Serious Mental Illness and Substance Abuse Rehabilitation Treatment.] 35.492

[You are entitled to a lifetime maximum of [10–1,000] Outpatient visits for Outpatient treatment of Mental Illness for those illnesses not classified as Serious Mental Illness.] 35.494

[You are entitled to a lifetime maximum of [10–1,000] Outpatient visits for Outpatient Substance Abuse Rehabilitation Treatment.] 35.495a

[A lifetime maximum of $[500–750,000] will apply to benefits for Outpatient Substance Abuse Rehabilitation Treatment.] 35.495b

[A combined lifetime maximum of $[500–750,000] will apply to benefits for Inpatient and Outpatient Substance Abuse Rehabilitation Treatment.]] 35.493

[None of the charges for the Inpatient and/or Outpatient treatment of Mental Illness for those illnesses not classified as Serious Mental Illness or Substance Abuse Rehabilitation Treatment will be included in the calculation of your out-of-pocket expenses.] 35.517

[BENEFIT PAYMENT FOR MENTAL ILLNESS, SUBSTANCE ABUSE REHABILITATION TREATMENT AND CHRONIC CONDITION MANAGEMENT

Your benefits for the treatment of Mental Illness, Substance Abuse Rehabilitation treatment and Chronic Condition Management are determined differently than the other benefits described in this Certificate. The benefit payment for the treatment of Mental Illness, Substance Abuse Rehabilitation treatment and Chronic Condition Management will be determined at the In-Network or Out-of-Network payment level.

Prior to receiving Covered Services for the treatment of Mental Illness, Substance Abuse Rehabilitation treatment or Chronic Condition Management you must, in order to receive maximum In-Network benefits, contact the Blue Cross and Blue Shield Mental Health Unit at 1-800-851-7498. When you contact the Blue Cross and Blue Shield Mental Health Unit, you will be referred to a specific Professional Provider for treatment.

Benefits for the treatment of Mental Illness, Substance Abuse Rehabilitation Treatment and Chronic Condition Management will be provided at the In-Network payment level only if you contact the Blue Cross and Blue Shield Mental Health Unit prior to receiving Covered Services and receive Covered Services from the Professional Provider to whom you have been referred by the Blue Cross and Blue Shield Mental Health Unit.

Benefits for the treatment of Mental Illness, Substance Abuse Rehabilitation Treatment and Chronic Condition Management will be provided at the Out-of-Network payment level if you contact the Blue Cross and Blue Shield Mental Health Unit but do not receive Covered Services from the Professional Provider to whom you have been referred by the Blue Cross and Blue Shield Mental Health Unit.

If you do not contact the Blue Cross and Blue Shield Mental Health Unit prior to receiving Covered Services for the treatment of Mental Illness, Substance Abuse Rehabilitation Treatment and Chronic Condition Management, benefits will be reduced by $[100–5,000] **and paid at the Out-of-Network payment level.**]

[**Outpatient Mental Illness Treatment**

Benefits for the Outpatient treatment of Serious Mental Illness will be provided at the In-Network payment levels previously described in this Certificate for Hospital and Physician Covered Services when you receive Covered Services In-Network.

[After you have met your program deductible, benefits for Outpatient treatment of Mental Illness for those illnesses not classified as Serious Mental Illness will be provided at [50–100]% of the Eligible Charge or at [50–100]% of the Maximum Allowance when you receive Covered Services In-Network.] 35.681

Benefits for the Outpatient treatment of Serious Mental Illness will be provided at the Out-of-Network payment levels previously described in this Certificate for Hospital and Physician Covered Services when you receive Covered Services Out-of-Network.

[After you have met your program deductible, benefits for Outpatient treatment of Mental Illness for those illnesses not classified as Serious Mental Illness will be provided at [50–100]% of the Eligible Charge or [50–100]% of the Maximum Allowance when you receive Covered Services Out-of-Network.] 35.682

[Your benefits for Outpatient treatment of Serious Mental Illness are limited to a maximum of [5–365] visits per benefit period. However, persons age 18 and under are entitled to [5–365] visits per benefit period for the Outpatient treatment of Serious Mental Illness.] 35.6831

[Your benefits for Outpatient treatment of Mental Illness for those illnesses not classified as Serious Mental Illness are limited to a maximum of [5–365] visits per benefit period. However, persons age 18 and under are entitled to [5–365] visits per benefit period for the Outpatient treatment of Mental Illness for those illnesses not classified as Serious Mental Illness.]] 35.683

[Outpatient Substance Abuse Rehabilitation Treatment

After you have met your program deductible, benefits for Outpatient Substance Abuse Rehabilitation Treatment will be provided at [50–100]% of the Eligible Charge or at [50–100]% of the Maximum Allowance when you receive Covered Services In-Network. 35.684

[When you receive Covered Services (in a program that has a written agreement with Blue Cross and Blue Shield) Out-of-Network for Outpatient Substance Abuse Rehabilitation Treatment, benefits will be provided at [50–100]% of the Eligible Charge or [50–100]% of the Maximum Allowance after you have met your program deductible.] 35.685

Benefits for Out-of-Network Substance Abuse Rehabilitation Treatment in a program that does not have a written agreement with Blue Cross and Blue Shield or in a Non-Plan Provider facility will be provided at 50% of the Eligible Charge after you have met your program deductible.

[Your benefits for Outpatient Substance Abuse Rehabilitation Treatment are limited to a maximum of [5–365] visits per benefit period. However, persons age 18 and under are entitled to a maximum of [5–365] visits per benefit period for Outpatient Substance Abuse Rehabilitation Treatment.]] 35.686

[Chronic Condition Management

Benefits for the treatment of Chronic Condition Management will be provided at [50–100]% of the Eligible Charge or at [50–100]% of the Maximum Allowance after you have met your program deductible when you receive Covered Services In-Network. When you receive Covered Services Out-of-Network for the treatment of Chronic Condition Management, benefits will be provided at [50–100]% of the Eligible Charge or [50–100]% of the Maximum Allowance after you have met your program deductible.

Your benefits for the treatment of Chronic Condition Management are limited to [one–10] visit[s] each month.] 35.687

[Inpatient Mental Illness and Substance Abuse Rehabilitation Treatment

Benefits for the Inpatient treatment of Serious Mental Illness will be provided at the In-Network payment levels previously described in this Certificate for Hospital and Physician Covered Services when you receive Covered Services In-Network.

[Benefits for the Inpatient treatment of Mental Illness for those illnesses not classified as Serious Mental Illness and Inpatient Substance Abuse Rehabilitation Treatment will be provided at [50–100]% of the Eligible Charge or at [50–100]% of the Maximum Allowance when you receive Covered Services In-Network[after you have met your program deductible].] 35.688

Benefits for the Inpatient treatment of Serious Mental Illness will be provided at the Out-of-Network payment levels previously described in this Certificate for Hospital and Physician Covered Services when you receive Covered Services Out-of-Network.

[After you have met your program deductible, benefits for the Inpatient treatment of Mental Illness for those illnesses not classified as Serious Mental Illness and Inpatient Substance Abuse Rehabilitation Treatment (in a program that has a written agreement with Blue Cross and Blue Shield) will be provided at [50–100]% of the Eligible Charge or at [50–100]% of the Maximum Allowance when you receive Covered Services Out-of-Network]. 35.689

[When you receive Out-of-Network Covered Services for the Inpatient treatment of Mental Illness or Substance Abuse Rehabilitation Treatment in a Non-Plan Provider facility, benefits will be provided at 50% of the Eligible Charge after you have met your program deductible.]

[You are entitled to a maximum of [45–365] Inpatient Hospital days each benefit period for the Inpatient treatment of Serious Mental Illness.

You are entitled to a maximum of [5–365] Inpatient Hospital days each benefit period for the Inpatient treatment of Mental Illness for those illnesses not classified as Serious Mental Illness and a maximum of [5–365] Inpatient Hospital days each benefit period for Inpatient Substance Abuse Rehabilitation Treatment.] 35.69

[For every two days of care in a Partial Hospitalization Treatment Program, one day is deducted from your Inpatient Hospital days for the treatment of Mental Illness or Substance Abuse Rehabilitation Treatment.]]

[None of the charges for the Inpatient and/or Outpatient treatment of Mental Illness for those illnesses not classified as Serious Mental Illness or Substance Abuse Rehabilitation Treatment will be applied in satisfying your Out-of-Pocket Expense Limit as explained later in this Certificate.]

[Lifetime Maximum for Mental Illness and Substance Abuse Rehabilitation Treatment

[A combined lifetime maximum of [10–1,000] Inpatient Hospital days will apply to benefits for Inpatient treatment of Mental Illness for those illnesses not classified as Serious Mental Illness and Substance Abuse Rehabilitation Treatment.] 35.692

[You are entitled to a lifetime maximum of [10–1,000] Inpatient Hospital days for Inpatient treatment of Mental Illness for those illnesses not classified as Serious Mental Illness.] 35.691

[You are entitled to a lifetime maximum of [10–1,000] Inpatient Hospital days for Inpatient Substance Abuse Rehabilitation Treatment.] 35.694a

[A lifetime maximum of $[500–750,000] will apply to benefits for Inpatient Substance Abuse Rehabilitation Treatment.] 35.694b

[A combined lifetime maximum of [10–1,000] Outpatient visits will apply to benefits for Outpatient treatment of Mental Illness for those illnesses not classified as Serious Mental Illness and Substance Abuse Rehabilitation Treatment.] 35.693 35.68b

[You are entitled to a lifetime maximum of [10–1,000] Outpatient visits for Outpatient treatment of Mental Illness for those illnesses not classified as Serious Mental Illness.] 35.695

[You are entitled to a lifetime maximum of[10–1,000] Outpatient visits for Outpatient Substance Abuse Rehabilitation Treatment.] 35.696a

[A lifetime maximum of $[500–750,000] will apply to benefits for Outpatient Substance Abuse Rehabilitation Treatment.] 35.696b

[Your benefits for the Inpatient of Mental Illness for those illnesses not classified as Serious Mental Illness and Substance Abuse Rehabilitation Treatment are limited to a combined lifetime maximum of [10–1,000] Inpatient days. However, the maximum days you are entitled to for Out-of-Network Inpatient treatment of Mental Illness for those illnesses not classified as Serious Mental Illness and Substance Abuse Rehabilitation Treatment is a combined lifetime maximum of [10–1,000] Inpatient days. 35.697

[Your benefits for Outpatient Substance Abuse Rehabilitation Treatment are limited to a lifetime maximum of $[500–750,000]. However, the amount you are entitled to for Out-of-Network Outpatient Substance Abuse Rehabilitation Treatment is a lifetime maximum of $[500–750,000].]] 35.698

AUTISM SPECTRUM DISORDER(S) New 10/09

Your benefits for the diagnosis and treatment of Autism Spectrum Disorder(s) are the same as your benefits for any other condition when rendered (A) by a Physician, a Psychologist, or other licensed health care Provider who has determined that such care is Medically Necessary, or (B) by a certified, registered, or licensed health care professional with expertise in treating Autism Spectrum Disorder(s) and when such care is determined to be Medically Necessary and ordered by a Physician, a Psychologist or other licensed health care Provider.

Treatment for Autism Spectrum Disorder(s) shall include:

- psychiatric care, including diagnostic services;
- psychological assessments and treatments;
- habilitative or rehabilitative treatments;
- therapeutic care, including behavioral Speech, Occupational and Physical Therapies that provide treatment in the following areas: a) self care and feeding, b) pragmatic, receptive and expressive language, c) cognitive functioning, d) applied behavior analysis (ABA), intervention and modification, e) motor planning and f) sensory processing.

HABILITATIVE SERVICES New 10/09

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

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

Congenital, Genetic, and Early Acquired Disorders may include, but are not limited to, autism or an Autism Spectrum Disorder, cerebral palsy, and other disorders resulting from early childhood illness, trauma, or injury.

MATERNITY SERVICE

Your benefits for Maternity Service are the same as your benefits for any other condition and are available whether you have Individual Coverage or Family Coverage. Benefits will also be provided for Covered Services rendered by a Certified Nurse-Midwife.

Benefits will be paid for Covered Services received in connection with both normal pregnancy and Complications of Pregnancy. As part of your maternity benefits certain services rendered to your newborn infant are also covered, even if you have Individual Coverage. These Covered Services are: a) the routine Inpatient Hospital nursery charges, b) one routine Inpatient examination as long as this examination is rendered by a Physician other than the Physician who delivered the child or administered anesthesia during delivery and c) one Inpatient hearing screening. (If the newborn child needs treatment for an illness, injury, congenital defect, birth abnormality or a premature birth, benefits will be available for that care from the moment of birth up to the first 31[31–60] days, thereafter, you must add the newborn child to your Family Coverage. You may apply for Family Coverage within 31 days of the date of the birth. Your Family Coverage will then be effective from the date of the birth.) **Revised**

Benefits will be provided for any hospital length of stay in connection with childbirth for the mother or newborn child for no less than 48 hours following a normal vaginal delivery, or no less than 96 hours following a cesarean section. Your Provider will not be required to obtain authorization from Blue Cross and Blue Shield for prescribing a length of stay less than 48 hours (or 96 hours).

[Your coverage also includes benefits for elective abortions if legal where performed.] 35.41

INFERTILITY TREATMENT

Benefits will be provided the same as your benefits for any other condition 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 that a medical condition exists that makes 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; or, efforts to conceive as a result of one year of medically based and supervised methods of conception, including artificial insemination, have failed and are not likely to lead to a successful pregnancy. **Revised**

Unprotected sexual intercourse means sexual union between a male and 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 and includes appropriate measures to ensure the health and safety of sexual partners. **Revised**

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 makes such treatment useless; and

— You have not undergone four completed oocyte retrievals, except that if a live birth followed a completed oocyte retrieval, two more completed oocyte retrievals shall be covered.

Benefits will also be provided for medical expenses of an oocyte or sperm donor for procedures used to retrieve oocytes or sperm and the subsequent procedure 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 that are eligible for coverage under this Certificate in your lifetime is six. 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. **Revised**

Special Limitations

Benefits will not be provided for the following:

1. 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.
2. Selected termination of an embryo; provided, however, termination will be covered where the mother's life would be in danger if all embryos were carried to full term.
3. Expenses incurred for cryo-preservation or storage of sperm, eggs or embryos, except for those procedures which use a cryo-preserved substance.
4. Non-medical costs of an egg or sperm donor.
5. Travel costs for travel within 100 miles of your home or travel costs not Medically Necessary or required by Blue Cross and Blue Shield.
6. Infertility treatments which are deemed Investigational, in writing, by the American Society for Reproductive Medicine or the American College of Obstetricians or Gynecologists.
7. Infertility treatment rendered to your dependents under age 18.

In addition to the above provisions, in-vitro fertilization, gamete intrafallopian tube transfer, zygote intrafallopian tube transfer, low tubal ovum transfer and intracytoplasmic sperm injection procedures must be performed at medical facilities that

conform to the American College of Obstetricians and Gynecologists guidelines for in-vitro fertilization clinics or to the American Society for Reproductive Medicine minimal standards for programs of in-vitro fertilization.

[TEMPOROMANDIBULAR JOINT DYSFUNCTION AND RELATED DISORDERS

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

[Your benefits for the diagnosis and/or treatment of Temporomandibular Joint Dysfunction and Related Disorders are limited to a lifetime maximum of $[500–100,000][Out-of-Network].] 35.54a 35.54a1

[However, your benefits for the diagnosis and/or treatment of Temporomandibular Joint Dysfunction and Related Disorders are limited to a benefit period maximum of $500[500–100,000].]] 35.54b 35.54

MASTECTOMY-RELATED SERVICES

Benefits for Covered Services related to mastectomies are the same as for any other condition. Mastectomy-related Covered Services include, but are 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. Inpatient care following a mastectomy for the length of time determined by your 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 48 hours after discharge; and
4. Prostheses and physical complications of all stages of the mastectomy including, but not limited to, lymphedemas.

[PAYMENT PROVISIONS

Lifetime Maximum

[The total maximum amount of benefits to which you are entitled under this benefit program is $[250,000–10,000,000]. This is an individual maximum. There is no family maximum.] 35.50a

[As you use your benefits, a certain amount will automatically be restored to your lifetime maximum each year. This amount will be $[500–100,000] or the amount you have received in benefits that benefit period, whichever is less.] 35.50a1

[The total dollar amount that will be available in benefits for you is unlimited subject to the separate dollar maximums for specific Covered Services described earlier in this Certificate.] 35.50b

[When Covered Services are received In-Network, the total dollar amount that will be available in benefits for you is unlimited subject to the separate dollar maximums for specific Covered Services described earlier in this Certificate.

When you receive Covered Services Out-of-Network, the total maximum amount of benefits to which you are entitled is $[250,000–10,000,000]. There is no family maximum.[As you use your benefits, a certain amount will automatically be restored to your lifetime maximum each year. This amount will be $[500–100,000] or the amount you have received in benefits for Covered Services received Out-of-Network that benefit period, whichever is less.]] 35.50c 35.50c1

[Cumulative Benefit Maximums

All benefits payable under this Certificate are cumulative. Therefore, in calculating the benefit maximums payable for a particular Covered Service or in calculating the remaining balance under the Lifetime Maximums, Blue Cross and Blue Shield will include benefit payments under both this and/or any prior or subsequent Blue Cross and Blue Shield Certificate issued to you as an Eligible Person or a dependent of an Eligible Person under this Group.]] 35.501

[OUT-OF-POCKET EXPENSE LIMIT 35.51

[There are separate Out-of-Pocket Expense Limits applicable to Covered Services received In-Network and Out-of-Network.]

[In-Network

[If, during one benefit period, your In-Network out-of-pocket expense (the amount remaining unpaid after benefits have been provided) equals $[100–20,000], any additional In-Network eligible Claims (except for those Covered Services specifically excluded below) during that benefit period will be paid at 100% of the Eligible Charge or Maximum Allowance.] 35.51PD

[If, during one benefit period, your In-Network out-of-pocket expense (the amount remaining unpaid after In-Network benefits have been provided) equals the In-Network individual out-of-pocket expense limit in the Benefit Highlights (an insert) of this Certificate, any additional In-Network eligible Claims (except for those Covered Services specifically excluded below) during that benefit period will be paid at 100% of the Eligible Charge or Maximum Allowance.] 35.51PG

This out-of-pocket expense limit may be reached by:

- [the [In-Network]program deductible] 35.518a 35.01b
- [the Inpatient Hospital admission deductible(s) In-Network] 35.514a1
- the payments for which you are responsible after benefits have been provided (except for any expenses incurred for Covered Services received Out-of-Network or rendered by a Non-Plan Provider other than Emergency Accident Care, Emergency Medical Care and Inpatient treatment during the period of time when your condition is serious)
- [the Hospital emergency room Copayment In-Network] 35.515a
- [the Copayment for Physician office visits In-Network] 35.516a1

- [any expenses incurred for Covered Services during the last 3 months of the prior benefit period which were or could have been applied to that benefit period's In-Network out-of-pocket expense limit] 35.520a
- [and any unreimbursed expenses incurred for "comprehensive major medical" covered services within your prior contract's benefit period, if not completed] 35.511

The following expenses for Covered Services cannot be applied to the In-Network out-of-pocket expense limit and will not be paid at 100% of the Eligible Charge or Maximum Allowance when your In-Network out-of-pocket expense limit is reached:

- [the program deductible(s)] 35.518b
- [the Inpatient Hospital admission deductible(s)] 35.514a2
- charges that exceed the Eligible Charge or Maximum Allowance
- the Coinsurance resulting from Covered Services received Out-of-Network or rendered by a Non-Plan Provider
- [charges for Covered Services which have a separate dollar maximum specifically mentioned in this Certificate] 35.519a
- [charges for Covered Services received for the treatment of Mental Illness for those illnesses not classified as Serious Mental Illness and/or Substance Abuse Rehabilitation Treatment] 35.517
- [charges for Outpatient prescription drugs] 35.513
- [the Hospital emergency room Copayment] 35.515b
- [the Copayment for Physician office visits] 35.516a2
- Copayments resulting from noncompliance with the provisions of the [Medical Services Advisory Program][Utilization Review Program][and/or the Blue Cross and Blue Shield Mental Health Unit]
- [and any unreimbursed expenses incurred for "comprehensive major medical" covered services within your prior contract's benefit period, if not completed] 35.512 35.51IN

[If you have Family Coverage and [2,3] members of your family have reached their In-Network out-of-pocket expense limit during one benefit period, then, for the rest of the benefit period, all other family members will have benefits for Covered Services (except for those Covered Services specifically excluded above) provided at 100% of the Eligible Charge or Maximum Allowance.] 35.52aIN

[If you have Family Coverage and your In-Network out-of-pocket expense as described above equals $[200–60,000] during one benefit period, then, for the rest of the benefit period, all other family members will have benefits for Covered Services (except for those Covered Services specifically excluded above) provided at 100% of the Eligible Charge or Maximum Allowance. A member may not apply more than the individual out-of-pocket expense limit toward this amount.]] 35.52bIN

[If you have Family Coverage and during one benefit period your In-Network out-of-pocket expense as described above equals the In-Network family out-of-pocket expense limit in the Benefit Highlights (an insert) of this Certificate, then, for the rest of the benefit period, all other family members will have benefits for Covered Services (except for those Covered Services specifically excluded above) provided at

100% of the Eligible Charge or Maximum Allowance. A member may not apply more than the individual out-of-pocket expense limit toward this amount.] 35.52bGIN

[**Out-of-Network**

[If, during one benefit period, your Out-of-Network out-of-pocket expense (the amount remaining unpaid after Out-of-Network benefits have been provided) equals $[100–20,000], any additional eligible Out-of-Network Claims (except for those Covered Services specifically excluded below) during that benefit period will be paid at 100% of the Eligible Charge or Maximum Allowance.] 35.51NPD

[If, during one benefit period, your Out-of-Network out-of-pocket expense (the amount remaining unpaid after Out-of-Network benefits have been provided) equals the Out-of-Network individual out-of-pocket expense limit in the Benefit Highlights (an insert) of this Certificate, any additional Out-of-Network eligible Claims (except for those Covered Services specifically excluded below) during that benefit period will be paid at 100% of the Eligible Charge or Maximum Allowance.] 35.51NPG

This out-of-pocket expense limit may be reached by:

- [the [Out-of-Network]program deductible] 35.518a1 35.01b
- [the Inpatient Hospital admission deductible(s) Out-of-Network] 35.514b1
- the payments for Covered Services received Out-of-Network for which you are responsible after benefits have been provided
- [the Hospital emergency room Copayment Out-of-Network] 35.515a1
- [the Copayment for Physician office visits Out-of-Network] 35.516b1
- [any expenses incurred for Covered Services during the last 3 months of the prior benefit period which were or could have been applied to that benefit period's Out-of-Network out-of-pocket expense limit] 35.520b

The following expenses for Covered Services cannot be applied to the Out-of-Network out-of-pocket expense limit and will not be paid at 100% of the Eligible Charge or Maximum Allowance when your Out-of-Network out-of-pocket expense limit is reached:

- [the program deductible(s)] 35.518b1
- [the Inpatient Hospital admission deductible(s)] 35.514b2
- charges that exceed the Eligible Charge or Maximum Allowance
- the Coinsurance resulting from In-Network Covered Services
- the Coinsurance resulting from Hospital services rendered by a Non-Plan Hospital or other Non-Plan Provider facility for Covered Services
- [charges for Covered Services which have a separate dollar maximum specifically mentioned in this Certificate] 35.519b
- [charges for Covered Services received for the treatment of Mental Illness for those illnesses not classified as Serious Mental Illness and/or Substance Abuse Rehabilitation Treatment] 35.5171
- [charges for Outpatient prescription drugs] 35.5131

- [the Hospital emergency room Copayment] 35.515a2
- [the Copayment for Physician office visits] 35.516b2
- Copayments resulting from noncompliance with the provisions of the [Medical Services Advisory Program][Utilization Review Program][and/or the Blue Cross and Blue Shield Mental Health Unit] 35.516a2
- any unreimbursed expenses incurred for "comprehensive major medical" covered services within your prior contract's benefit period 35.51NP 35.51

[If you have Family Coverage and [2,3] members of your family have reached their Out-of-Network out-of-pocket expense limit during one benefit period, then, for the rest of the benefit period, all other family members will have benefits for Covered Services (except for those Covered Services specifically excluded above) provided at 100% of the Eligible Charge or Maximum Allowance.] 35.52aON

[If you have Family Coverage and your Out-of-Network out-of-pocket expense as described above equals $[200–60,000] during one benefit period, then, for the rest of the benefit period, all other family members will have benefits for Covered Services (except for those Covered Services specifically excluded above) provided at 100% of the Eligible Charge or Maximum Allowance. A member may not apply more than the individual out-of-pocket expense limit toward this amount.]] 35.52bON

[If you have Family Coverage and during one benefit period your Out-of-Network out-of-pocket expense as described above equals the Out-of-Network family out-of-pocket expense limit in the Benefit Highlights (an insert) of this Certificate, then, for the rest of the benefit period, all other family members will have benefits for Covered Services (except for those Covered Services specifically excluded above) provided at 100% of the Eligible Charge or Maximum Allowance. A member may not apply more than the individual out-of-pocket expense limit toward this amount.] 35.52bGON

[OUT-OF-POCKET EXPENSE LIMIT

If you have Individual Coverage and your out-of-pocket expense during one benefit period (the amount remaining unpaid for Covered Services after benefits have been provided) equals $[100–20,000], any additional eligible Claims (except for those charges specifically excluded below) during that benefit period will be paid at 100% of the Eligible Charge or Maximum Allowance. 35.71D

[If you have Individual Coverage and your out-of-pocket expense (the amount remaining unpaid for Covered Services after benefits have been provided) during one benefit period equals the individual out-of-pocket expense limit in the Benefit Highlights (an insert) of this Certificate, any additional eligible Claims (except for those Covered Services specifically excluded below) during that benefit period will be paid at 100% of the Eligible Charge or Maximum Allowance.] 35.71G

This out-of-pocket expense limit may be reached by:

- [the program deductible] 35.711a
- [the Inpatient Hospital admission deductible(s)] 35.712a
- [the Hospital emergency room Copayment] 35.713a
- [the Copayment for Physician office visits] 35.714a

- the payments for which you are responsible after benefits have been provided
- [and any unreimbursed expenses incurred for "comprehensive major medical" covered services within your prior contract's benefit period, if not completed] 35.715a

The following expenses for Covered Services cannot be applied to the out-of-pocket expense limit and will not be paid at 100% of the Eligible Charge or Maximum Allowance when your out-of-pocket expense limit is reached:

- [the program deductible] 35.711b
- [the Inpatient Hospital admission deductible(s)] 35.712b
- [charges for Covered Services which have a separate dollar maximum specifically mentioned in this Certificate] 35.716
- [charges for Covered Services received for the treatment of Mental Illness for those illnesses not classified as Serious Mental Illness and/or Substance Abuse Rehabilitation Treatment] 35.717
- [charges for Outpatient prescription drugs] 35.718
- [the Hospital emergency room Copayment] 35.713b
- [the Copayment for Physician office visits] 35.714b
- charges that exceed the Eligible Charge or Maximum Allowance
- Copayments resulting from noncompliance with the provisions of the [Medical Services Advisory Program][Utilization Review Program][and/or the Blue Cross and Blue Shield Mental Health Unit]
- [and any unreimbursed expenses incurred for "comprehensive major medical" covered services within your prior contract's benefit period, if not completed] 35.715b

[If you have Family Coverage and your family's out-of-pocket expense (the amount remaining unpaid for Covered Services after benefits have been provided) equals $[200–60,000] during one benefit period, then, for the rest of the benefit period, all other family members will have benefits for eligible Covered Services (except for those charges specifically excluded above) provided at 100% of the Eligible Charge or Maximum Allowance. Benefits under Family Coverage will not be provided at the 100% payment level until the entire family out-of-pocket expense limit has been met.] 35.52cD

[If you have Family Coverage and during one benefit period your family's out-of-pocket expense as described above equals the family out-of-pocket expense limit in the Benefit Highlights (an insert) of this Certificate, then, for the rest of the benefit period, all other family members will have benefits for Covered Services (except for those Covered Services specifically excluded above) provided at 100% of the Eligible Charge or Maximum Allowance. Benefits under Family Coverage will not be provided at the 100% payment level until the entire family out-of-pocket expense limit has been met.] 35.52cG

[**The out-of-pocket expense limit amount may be adjusted based on the cost-of-living adjustment determined under the Internal Revenue Code and rounded to the nearest $50.**]] 35.71

[OUT-OF-POCKET EXPENSE LIMIT 35.81

There are separate Out-of-Pocket Expense Limits applicable to Covered Services received In-Network and Out-of-Network.]

[In-Network

[If you have Individual Coverage and your In-Network out-of-pocket expense (the amount remaining unpaid for Covered Services after benefits have been provided) during one benefit period equals $[100–20,000], any additional In-Network eligible Claims (except for those charges specifically excluded below) during that benefit period will be paid at 100% of the Eligible Charge or Maximum Allowance.] 35.81IND

[If you have Individual Coverage and your In-Network out-of-pocket expense (the amount remaining unpaid for Covered Services after benefits have been provided) during one benefit period equals the In-Network individual out-of-pocket expense limit in the Benefit Highlights (an insert) of this Certificate, any additional In-Network eligible Claims (except for those Covered Services specifically excluded below) during that benefit period will be paid at 100% of the Eligible Charge or Maximum Allowance.] 35.81ING

This out-of-pocket expense limit may be reached by:

- [the [In-Network]program deductible] 35.818a 35.01e
- [the Inpatient Hospital admission deductible(s) In-Network] 35.814a1
- the payments for Covered Services for which you are responsible after benefits have been provided (except for any expenses incurred for Covered Services received Out-of-Network or rendered by a Non-Plan Provider other than Emergency Accident Care, Emergency Medical Care and Inpatient treatment during the period of time when your condition is serious)
- [the Hospital emergency room Copayment In-Network] 35.815a1
- [the Copayment for Physician office visits In-Network] 35.816a1
- [and any unreimbursed expenses incurred for "comprehensive major medical" covered services within your prior contract's benefit period, if not completed] 35.817a1

The following expenses for Covered Services cannot be applied to the out-of-pocket expense limit and will not be paid at 100% of the Eligible Charge or Maximum Allowance when your out-of-pocket expense limit is reached:

- [the program deductible(s)] 35.818b
- [the Inpatient Hospital admission deductible(s)] 35.814a2
- charges that exceed the Eligible Charge or Maximum Allowance
- [the Coinsurance resulting from Out-of-Network Covered Services]
- the Coinsurance resulting from Covered Services rendered by a Non-Plan Hospital or other Non-Plan Provider facility
- [charges for Covered Services which have a separate dollar maximum specifically mentioned in this Certificate] 35.819a

- [charges for Covered Services received for the treatment of Mental Illness for those illnesses not classified as Serious Mental Illness and/or Substance Abuse Rehabilitation Treatment] 35.820a
- [charges for Outpatient prescription drugs] 35.821a
- [the Hospital emergency room Copayment] 35.815a2
- [the Copayment for Physician office visits] 35.816a2
- Copayments resulting from noncompliance with the provisions of the [Medical Services Advisory Program][Utilization Review Program][and/or the Blue Cross and Blue Shield Mental Health Unit]
- [and any unreimbursed expenses incurred for "comprehensive major medical" covered services within your prior contract's benefit period, if not completed] 35.817a2 35.81IN

[If you have Family Coverage and your family's out-of-pocket expense (the amount remaining unpaid for Covered Services after benefits have been provided) equals $[200–60,000] during one benefit period, then, for the rest of the benefit period, all other family members will have benefits for eligible Covered Services (except for those charges specifically excluded above) provided at 100% of the Eligible Charge or Maximum Allowance. Benefits under Family Coverage will not be provided at the 100% payment level until the entire family out-of-pocket expense limit has been met.] 35.52dIND

[If you have Family Coverage and during one benefit period your In-Network out-of-pocket expense as described above equals the In-Network family out-of-pocket expense limit in the Benefit Highlights (an insert) of this Certificate, then, for the rest of the benefit period, all other family members will have benefits for Covered Services (except for those Covered Services specifically excluded above) provided at 100% of the Eligible Charge or Maximum Allowance. Benefits under Family Coverage will not be provided at the 100% payment level until the entire family out-of-pocket expense limit has been met.] 35.52dING

[**Out-of-Network**

[If you have Individual Coverage and your Out-of-Network out-of-pocket expense (the amount remaining unpaid for Covered Services after benefits have been provided) during one benefit period equals $[100–20,000], any additional Out-of-Network eligible Claims (except for those Covered Services specifically excluded below) during that benefit period will be paid at 100% of the Eligible Charge or Maximum Allowance.] 35.81OND

[If you have Individual Coverage and your Out-of-Network out-of-pocket expense (the amount remaining unpaid for Covered Services after benefits have been provided) during one benefit period equals the Out-of-Network individual out-of-pocket expense limit in the Benefit Highlights (an insert) of this Certificate, any additional eligible Out-of-Network Claims (except for those Covered Services specifically excluded below) during that benefit period will be paid at 100% of the Eligible Charge or Maximum Allowance.] 35.81ONG

This out-of-pocket expense limit may be reached by:

- [the [Out-of-Network]program deductible] 35.818a1 35.01e

- [the Inpatient Hospital admission deductible(s) Out-of-Network] 35.814b1
- the payments for Out-of-Network Covered Services for which you are responsible after benefits have been provided
- [the Hospital emergency room Copayment Out-of-Network] 35.815b1
- [the Copayment for Physician office visits Out-of-Network] 35.816b1

The following expenses for Covered Services cannot be applied to the out-of-pocket expense limit and will not be paid at 100% of the Eligible Charge or Maximum Allowance when your out-of-pocket expense limit is reached:

- [the program deductible(s)] 35.818b1
- [the Inpatient Hospital admission deductible(s)] 35.814b2
- charges that exceed the Eligible Charge or Maximum Allowance
- [the Coinsurance resulting from In-Network Covered Services]
- the Coinsurance resulting from Covered Services rendered by a Non-Plan Hospital or other Non-Plan Provider facility
- [charges for Covered Services which have a separate dollar maximum specifically mentioned in this Certificate] 35.819b
- [charges for Covered Services received for the treatment of Mental Illness for those illnesses not classified as Serious Mental Illness and/or Substance Abuse Rehabilitation Treatment] 35.820b
- [charges for Outpatient prescription drugs] 35.821b
- [the Hospital emergency room Copayment] 35.815b2
- [the Copayment for Physician office visits] 35.816b2
- Copayments resulting from noncompliance with the provisions of the [Medical Services Advisory Program][Utilization Review Program][and/or the Blue Cross and Blue Shield Mental Health Unit]
- [and any unreimbursed expenses incurred for "comprehensive major medical" covered services within your prior contract's benefit period, if not completed] 35.81ON

[If you have Family Coverage and your family's out-of-pocket expense (the amount remaining unpaid for Covered Services after benefits have been provided) equals $[200–60,000] during one benefit period, then, for the rest of the benefit period, all other family members will have benefits for eligible Covered Services (except for those charges specifically excluded above) provided at 100% of the Eligible Charge or Maximum Allowance. Benefits under Family Coverage will not be provided at the 100% payment level until the entire family out-of-pocket expense limit has been met.] 35.52dD

[If you have Family Coverage and during one benefit period your Out-of-Network out-of-pocket expense as described above equals the Out-of-Network family out-of-pocket expense limit in the Benefit Highlights (an insert) of this Certificate, then, for the rest of the benefit period, all other family members will have benefits for Covered Services (except for those Covered Services specifically excluded above) provided at 100% of the Eligible Charge or Maximum Allowance. Benefits under Family Cover-

age will not be provided at the 100% payment level until the entire family out-of-pocket expense limit has been met.] 35.52dG

[**The out-of-pocket expense limit amount may be adjusted based on the cost-of-living adjustment determined under the Internal Revenue Code and rounded to the nearest $50.**]] 35.81

EXTENSION OF BENEFITS IN CASE OF TERMINATION

If you are an Inpatient at the time your coverage under this Certificate is terminated, benefits will be provided for, and limited to, the Covered Services of this Certificate which are rendered by and regularly charged for by a Hospital, Skilled Nursing Facility, Substance Abuse Treatment Facility, Partial Hospitalization Treatment Program or Coordinated Home Care Program. Benefits will be provided until you are discharged or until the end of your benefit period, whichever occurs first.

ADDITIONAL HUMAN ORGAN TRANSPLANTS COVERAGE PROGRAM

This section of your Certificate will explain to you the benefits available under the Additional Human Organ Transplants Coverage Program.

The benefits of this section are subject to all of the terms and conditions of this Certificate as well as your Employer's Health Care Benefit Plan. Your benefits are also subject to the Preexisting Condition waiting period. Please refer to the DEFINITIONS, ELIGIBILITY and EXCLUSIONS sections of this Certificate for additional information regarding any limitations and/or special conditions pertaining to your benefits for Additional Human Organ Transplants. 0.564

In addition, the Covered Services described below will be provided only when you receive Covered Services on or after your Coverage Date which are rendered upon the direction or under the direct care of your Physician. Such Covered Services must be Medically Necessary and regularly included in the Provider's charges.

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

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

Covered Services

Your Additional Human Organ Transplants coverage will provide benefits for Covered Services for a heart, lung, heart/lung, liver, pancreas or pancreas/kidney transplant. Your benefits under this Certificate will begin no earlier than 5 days prior to the transplant Surgery and shall continue for a period of no longer than 365 days after the transplant Surgery.

Benefits will be provided for:

— Inpatient and Outpatient Covered Services related to the transplant Surgery.

— the evaluation, preparation and delivery of the donor organ.

— the removal of the organ from the donor.

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

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

If 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 de-

pendent 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. 34.72

— You and your companion are each entitled to benefits for lodging and meals up to a combined maximum of $ per day. 34.721a [$x, $200]

— You and your companion are each entitled to benefits for lodging up to a combined maximum of $ per day. 34.721b [$x, $25]

— Benefits for transportation, lodging and meals are limited to a maximum of $ per transplant. 34.722a [$ x, $10,000]

— Benefits for transportation, lodging and meals are limited to a lifetime maximum of $. 34.722b [$x, $10,000]

Exclusions

In addition to the other exclusions of this Certificate, benefits will not be provided under the Additional Human Organ Transplants Coverage Program for the following:

1. Services unrelated to a heart, heart/lung, liver, pancreas or pancreas/kidney transplant or unrelated to the diagnosis or treatment of an illness resulting directly from such transplant.
2. Cardiac rehabilitation services when not provided to the transplant recipient immediately following discharge from a Hospital for Additional Human Organ Transplant Surgery.
3. Travel time and related expenses required by a Provider.
4. Drugs which do not have approval of the Food and Drug Administration.
5. Storage fees.
6. Services provided to any individual who is not the recipient or actual donor.

Benefit Payment for Additional Human Organ Transplants Coverage Program

Your Additional Human Organ Transplants benefits are subject to the deductible and out-of-pocket expense limit described in your Employer's Health Care Benefit Plan. Please refer to your Employer's Health Care Benefit Plan benefit booklet to determine your deductible and out-of-pocket expense limit.

After you have met your deductible, benefits for Covered Services will be provided at % of the Eligible Charge and % of the Usual and Customary FeeMaximum Allowance. 34.01

The total lifetime maximum amount of benefits to which you are entitled under the Additional Human Organ Transplants Coverage Program is $. This is an individual maximum. There is no family maximum. 34.02a

The total lifetime maximum amount of benefits to which you are entitled under the Additional Human Organ Transplants Coverage Program is the overall program lifetime maximum specifically mentioned in your Employer's Health Care Benefit Plan benefit booklet. This is an individual maximum. There is no family maximum. 34.02b

OUTPATIENT PRESCRIPTION DRUG PROGRAM BENEFIT SECTION

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.

Although you can go to the Pharmacy of your choice, your benefits for drugs and supplies will be greater when you purchase them from a Participating Prescription Drug Provider. You can visit the Blue Cross and Blue Shield of Illinois Web site at *www.bcbsil.com* for a list of Participating Prescription Drug Providers. The Pharmacies that are Participating Prescription Drug Providers may change from time to time. You should check with your Pharmacy before purchasing drugs or supplies to make certain of its participation status. **New 5/08**

The benefits of this section are subject to all of the terms and conditions of this Certificate. Please refer to the DEFINITIONS, ELIGIBILITY and EXCLUSIONS sections of this Certificate for additional information regarding any limitations and/or special conditions pertaining to your benefits.

For purposes of this Benefit Section only, the definition of Eligible Charge shall read as follows:

ELIGIBLE CHARGE.....means (a) in the case of a Provider which has a written agreement with a Blue Cross and Blue Shield Plan or the entity chosen by Blue Cross and Blue Shield to administer its prescription drug program to provide Covered Services to you at the time you receive the Covered Services, such Provider's Claim Charge for Covered Services and (b) in the case of a Provider which does not have a written agreement with a Blue Cross and Blue Shield Plan or the entity chosen by Blue Cross and Blue Shield to provide services to you at the time you receive Covered Services, either of the following charges for Covered Services:

(i) the charge which the particular Prescription Drug Provider usually charges for Covered Services, or

(ii) the agreed upon cost between Participating Prescription Drug Providers and a Blue Cross and Blue Shield Plan or the entity chosen by Blue Cross and Blue Shield to administer its prescription drug program, whichever is lower.

[Additionally, the following definition(s) shall apply to this Benefit Section:

[FORMULARY.....means a brand name drug or brand name diabetic supply that has been designated as a preferred drug or supply by Blue Cross and Blue Shield.] 5.01

[SPECIALTY DRUGS.....means prescription drugs generally prescribed for use in limited patient populations or diseases. These drugs are typically injected or infused, but may also include high cost oral medications. In addition, patient support and/or education may be required for these drugs. The list of Specialty Drugs is subject to change. You should refer to the formulary list, contact your Pharmacy or refer to the Blue Cross and Blue Shield of Illinois Web site (*www.bcbsil.com*) to determine which drugs are Specialty Drugs.]] 5.36 **New 5/08**

[SPECIALTY PHARMACY PROVIDER.....means a Participating Prescription Drug Provider that has a written agreement with Blue Cross and Blue Shield or the entity chosen by Blue Cross and Blue Shield to administer its prescription drug program to provide Specialty Drugs to you at the time you receive the Specialty Drugs.]] 5.36 **New 5/09**

[PRIOR AUTHORIZATION REQUIREMENT **Revised 5/09**

When certain medications and drug classes, such as medications used to treat rheumatoid arthritis, growth hormone deficiency, hepatitis C, and more serious forms of anemia, hypertension, asthma, epilepsy, and psoriasis are prescribed, your Physician will be required to obtain authorization from Blue Cross and Blue Shield. Medications included in this program are subject to change and other medications for other conditions may be added to the program.

Blue Cross and Blue Shield's prescription drug administrator will send a questionnaire to your Physician upon your or your Pharmacy's request. The questionnaire must be returned to the prescription drug administrator who will review the questionnaire 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 24 hours. If you do not obtain prior authorization, you will then be responsible for for the first $[100–1,000] or [5–50]% of the Eligible Charge, whichever is less.

You should refer to the formulary list, contact your Pharmacy or refer to the Blue Cross and Blue Shield of Illinois Web site (*www.bcbsil.com*) to determine which medications and drug classes require prior authorization.] 5.38

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;
- self-injectable insulin and insulin syringes;
- diabetic supplies, as follows: test strips, glucagon emergency kits and lancets.

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:[

- self-injectable drugs other than insulin;] 5.3
- drugs used for cosmetic purposes (including, but not limited to, Retin-A/Tretinoin and Minoxidil/Rogaine);[
- drugs used as anorexiants;] 5.22
- drugs used to treat impotence;][5.23

- nonsedating antihistamine drugs;][5.37
- combination medications containing a nonsedating antihistamine and decongestant;][5.37
- drugs for which there is an over-the-counter product available with the same active ingredient(s);] 5.39
- drugs which are not self-administered;
- any devices or appliances except as specifically mentioned above;
- any charges that you may incur for the drugs being administered to you.

In addition, benefits will not be provided for any refills if the prescription is more than one year old.

[Some prescription drug products may be more cost-effective than others without sacrificing quality. In some instances, you and your Physician may be contacted by your Pharmacy about switching to an alternative drug. The Pharmacy may not provide a substitute drug without the approval of you and your Physician. Please refer to the provision entitled "Blue Cross and Blue Shield's Separate Financial Arrangements with Prescription Drug Providers" in the GENERAL PROVISIONS section of this Certificate.] 5.43

[**Deductible**

[Each benefit period you must satisfy a $[25–5,000] deductible when you receive drugs and diabetic supplies from a Prescription Drug Provider(s). In other words, after you have eligible drug Claims for more than the deductible amount in a benefit period, your benefits for drugs and diabetic supplies will begin. The prescription drug deductible is separate from your program deductible for medical benefits.] 5.24

[If you have Family Coverage and [2,3] members of your family have each satisfied their prescription drug deductible, it will not be necessary for anyone else in your family to meet a prescription drug deductible in that benefit period. That is, for the remainder of that benefit period, no other family members will be required to meet a prescription drug deductible before receiving benefits. The prescription drug deductible is separate from your program deductible for medical benefits.] 5.25

[Each benefit period you must satisfy the[Participating Provider] program deductible described in this Certificate for your medical benefits before your benefits will begin for drugs and diabetic supplies. Expenses incurred by you for Covered Services under this Benefit Section will also be applied towards the program deductible.]] 5.46 5.461

[**Out-of-Pocket Expense Limit**

Expenses incurred by you for Covered Services under this Benefit Section will be applied towards the[Participating Provider] out-of-pocket expense limit described in this Certificate for your medical benefits. If, during one benefit period, your[Participating Provider] out-of-pocket expense limit is reached, any additional eligible Claims for drugs or diabetic supplies during that benefit period will be paid at 100% of the Eligible Charge.] 5.47 5.471 **New 5/08**

[**Specialty Pharmacy Program** **New 5/09**

In order to receive maximum benefits for Specialty Drugs, you must purchase the Specialty Drugs from a Specialty Pharmacy Provider. When you purchase Specialty

Drugs from a Specialty Pharmacy Provider, benefits will be provided according to the payment provisions described below for Participating Prescription Drug Providers.

[If you obtain Specialty Drugs from a Provider that is not a Specialty Pharmacy Provider, 75% of the Eligible Charge will be paid minus the Copayment amount.]

[If you obtain Specialty Drugs from a Provider that is not a Specialty Pharmacy Provider, benefits will be provided at 75% of the amount you would have received had you obtained drugs from a Specialty Pharmacy Provider.][When you are responsible for a Copayment, [50–100]% of the Eligible Charge will be paid minus the Copayment.]]

[**Benefit Payment for Prescription Drugs**

One prescription means up to a 34 consecutive day supply of a drug. 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 Home Delivery Prescription Drug Program. For information on these drugs, contact your Participating Prescription Drug Provider or your local Blue Cross and Blue Shield office. Benefits for prescription inhalants will not be restricted on the number of days before an inhaler refill may be obtained.

The benefits you receive for drugs will differ depending upon whether they are obtained from a Participating Prescription Drug Provider.

When you obtain drugs [(other than Specialty Drugs)]or diabetic supplies from a Participating Prescription Drug Provider, you must pay a Copayment amount of $[1–200] for each prescription.

[When you obtain Specialty Drugs from a Participating Prescription Drug Provider, you must pay a Copayment amount of $[1–200] for each prescription.] 5.11 **New 5/08**

When you obtain drugs or diabetic supplies from a non-Participating Prescription Drug Provider (other than a Participating Prescription Drug Provider), [50–100]75% of the Eligible Charge will be paid minus the Copayment amount.] 5.1

[**Benefit Payment for Prescription Drugs**

The benefits you receive and the Copayment amount you pay will differ depending upon the type of drugs purchased and whether they are obtained from a Participating Prescription Drug Provider.

When you obtain drugs [(other than Specialty Drugs)]or diabetic supplies from a Participating Prescription Drug Provider, you must pay a Copayment amount of:

- **$**[1–200] **for each prescription** – for generic[or brand name] drugs[for which there is no generic available (other than self-injectable drugs)] and generic[or brand name] diabetic supplies[for which there is no generic available]. 5.42
- **$**[1–200] **for each prescription** – for brand name drugs[(other than self-injectable drugs)] and brand name diabetic supplies.[
- **$**[1–200] **for each prescription** – for self-injectable drugs other than insulin[and infertility drugs].[5.41

[When you obtain Specialty Drugs from a Participating Prescription Drug Provider, you must pay a Copayment amount of **$**[1–200] **for each prescription**.] 5.43 **New 5/08**

When you obtain drugs or diabetic supplies from a Participating Prescription Drug Provider, you must pay the Copayment amount described above for each prescription. Benefits will be provided for the remaining Eligible Charge. One prescription means up to a 34 consecutive day supply of a drug. 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 Home Delivery Prescription Drug Program. For information on these drugs, contact your Participating Prescription Drug Provider or your local Blue Cross and Blue Shield office. Benefits for prescription inhalants will not be restricted on the number of days before an inhaler refill may be obtained.

When you obtain drugs or diabetic supplies from a non-Participating Prescription Drug Provider (other than a Participating Prescription Drug Provider), [50–100]75% of the Eligible Charge will be paid minus the Copayment amount.] 5.4

[**Benefit Payment for Prescription Drugs**

The benefits you receive and the Copayment amount you pay will differ depending upon the type of drugs purchased and whether they are obtained from a Participating Prescription Drug Provider.

When you obtain drugs [(other than Specialty Drugs)]or diabetic supplies from a Participating Prescription Drug Provider, you must pay a Copayment amount of:

- **$**[1–200] **for each prescription** – for generic drugs and diabetic suppliesand generic diabetic supplies.
- **$**[1–200] **for each prescription** – for Formulary brand name drugs and Formulary brand name diabetic supplies.
- **$**[1–200] **for each prescription** – for non-Formulary brand name drugs and non-Formulary brand name diabetic supplies.[
- **$**[1–200] **for each prescription** – for self-injectable drugs other than insulin[and infertility drugs].] 5.141 5.142

[When you obtain Specialty Drugs from a Participating Prescription Drug Provider, you must pay a Copayment amount of **$**[1–200] **for each prescription**.] 5.143 **New 5/08**

When you obtain drugs or diabetic supplies from a Participating Prescription Drug Provider, you must pay the Copayment amount described above for each prescription. Benefits will be provided for the remaining Eligible Charge. 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 Home Delivery Prescription Drug Program. For information on these drugs, contact your Participating Prescription Drug Provider or your local Blue Cross and Blue Shield office. Benefits for prescription inhalants will not be restricted on the number of days before an inhaler refill may be obtained.

When you obtain drugs or diabetic supplies from a non-Participating Prescription Drug Provider (other than a Participating Prescription Drug Provider), [50–100]75% of the Eligible Charge will be paid minus the Copayment amount.] 5.14

[**Benefit Payment for Prescription Drugs**

The benefits you receive and the Copayment amount you pay will differ depending upon the type of drugs purchased and whether they are obtained from a Participating Prescription Drug Provider.

When you obtain drugs [(other than Specialty Drugs)]or diabetic supplies from a Participating Prescription Drug Provider, you must pay a Copayment amount of:

- **$**[1–200] **for each prescription** – for generic drugs and generic diabetic supplies and diabetic supplies.
- **$**[1–200] **for each prescription** – for Formulary brand name drugs and Formulary brand name diabetic supplies.
- **$**[1–200] **for each prescription** – for non-Formulary brand name drugs and non-Formulary brand name diabetic supplies for which **there is no generic** drug or supply available.
- [If your Physician indicates dispense as written on the prescription, you will be responsible for the Copayment amount specified above and the following provision will not apply.

  ]**$**[1–200]**, plus the cost difference between the generic and brand name drugs or supplies, as determined by Blue Cross and Blue Shield, for each prescription** – for non-Formulary brand name drugs and non-Formulary brand name diabetic supplies for which **there is a generic** drug or supply available.
- **$**[1–200] **for each prescription** – for self-injectable drugs other than insulin[and infertility drugs]. 5.301

[When you obtain Specialty Drugs from a Participating Prescription Drug Provider, you must pay a Copayment amount of **$**[1–200] **for each prescription**.] 5.304 **New 5/08**

When you obtain drugs or diabetic supplies from a Participating Prescription Drug Provider, you must pay the Copayment amount described above for each prescription. Benefits will be provided for the remaining Eligible Charge. 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 Home Delivery Prescription Drug Program. For information on these drugs, contact your Participating Prescription Drug Provider or your local Blue Cross and Blue Shield office. Benefits for prescription inhalants will not be restricted on the number of days before an inhaler refill may be obtained.

When you obtain drugs or diabetic supplies from a non-Participating Prescription Drug Provider (other than a Participating Prescription Drug Provider), [50–100]75% of the Eligible Charge will be paid minus the Copayment amount.] 5.30

[**Benefit Payment for Prescription Drugs**

The benefits you receive and the Copayment amount you pay will differ depending upon the type of drugs purchased and whether they are obtained from a Participating Prescription Drug Provider.

When you obtain drugs [(other than Specialty Drugs)]or diabetic supplies from a Participating Prescription Drug Provider, you must pay a Copayment amount of:

- **$**[1–200] **for each prescription** – for generic drugs and generic diabetic supplies and diabetic supplies.
- **$**[1–200] **for each prescription** – for brand name drugs and brand name diabetic supplies for which **there is no generic** drug or supply available.

- **$**[1–200] **for each prescription** – for brand name drugs and brand name diabetic supplies for which **there is a generic** drug or supply available.

[When you obtain Specialty Drugs from a Participating Prescription Drug Provider, you must pay a Copayment amount of **$**[1–200] **for each prescription**.] 5.161 **New 5/08**

When you obtain drugs or diabetic supplies from a Participating Prescription Drug Provider, you must pay the Copayment amount described above for each prescription. Benefits will be provided for the remaining Eligible Charge. One prescription means up to a 34 consecutive day supply of a drug. 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 Home Delivery Prescription Drug Program. For information on these drugs, contact your Participating Prescription Drug Provider or your local Blue Cross and Blue Shield office. Benefits for prescription inhalants will not be restricted on the number of days before an inhaler refill may be obtained.

When you obtain drugs or diabetic supplies from a non-Participating Prescription Drug Provider (other than a Participating Prescription Drug Provider), [50–100]75% of the Eligible Charge will be paid minus the Copayment amount.] 5.16

[**Benefit Payment for Prescription Drugs**

The benefits you receive and the Copayment amount you pay will differ depending upon the type of drugs purchased and whether they are obtained from a Participating Prescription Drug Provider.

When you obtain drugs [(other than Specialty Drugs)]or diabetic supplies from a Participating Prescription Drug Provider, you must pay a Copayment amount of:

- **$**[1–200] **for each prescription** – for generic drugs and generic diabetic supplies and diabetic supplies.
- **$**[1–200] **for each prescription** – for brand name drugs and brand name diabetic supplies for which **there is no generic** drug or supply available.
- [If your Physician indicates dispense as written on the prescription, you will be responsible for the Copayment amount specified above and the following provision will not apply. 5.281

  ]**$**[1–200]**, plus the cost difference between the generic and brand name drugs or supplies, as determined by Blue Cross and Blue Shield, for each prescription** – for brand name drugs and brand name diabetic supplies for which **there is a generic** drug or supply available.

[When you obtain Specialty Drugs from a Participating Prescription Drug Provider, you must pay a Copayment amount of **$**[1–200] **for each prescription**.] 5.282 **New 5/08**

When you obtain drugs or diabetic supplies from a Participating Prescription Drug Provider, you must pay the Copayment amount described above for each prescription. Benefits will be provided for the remaining Eligible Charge. One prescription means up to a 34 consecutive day supply of a drug. 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 Home Delivery Prescription Drug Program. For information on these drugs, contact your Participating Prescription Drug Provider or your local Blue Cross and Blue Shield office. Benefits for prescription inhalants will not be restricted on the number of days before an inhaler refill may be obtained.

When you obtain drugs or diabetic supplies from a non-Participating Prescription Drug Provider (other than a Participating Prescription Drug Provider), [50–100]75% of the Eligible Charge will be paid minus the Copayment amount.] 5.28

[**Benefit Payment for Prescription Drugs**

The benefits you receive for drugs will differ depending upon whether they are obtained from a Participating Prescription Drug Provider.

When you obtain drugs [(other than Specialty Drugs)]or diabetic supplies from a Participating Prescription Drug Provider, benefits will be provided at [50–100]% of the Eligible Charge for each prescription.

[When you obtain Specialty Drugs from a Participating Prescription Drug Provider, benefits will be provided at [50–100]% of the Eligible Charge for each prescription.] 5.441 **New 5/08**

One prescription means up to a 34 consecutive day supply of a drug. 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 Home Delivery Prescription Drug Program. For information on these drugs, contact your Participating Prescription Drug Provider or your local Blue Cross and Blue Shield office. Benefits for prescription inhalants will not be restricted on the number of days before an inhaler refill may be obtained.

[When you obtain drugs or diabetic supplies from a non-Participating Prescription Drug Provider (other than a Participating Prescription Drug Provider), [50–100]75% of the [Eligible Charge][Claim Charge] will be paid.] 5.44

[When you obtain drugs or diabetic supplies from a non-Participating Prescription Drug Provider (other than a Participating Prescription Drug Provider), benefits will be provided at [50–100]75% of the amount you would have received had you obtained drugs from a Participating Prescription Drug Provider.]] 5.44 **New 5/08**

[**Benefit Payment for Prescription Drugs**

The benefits you receive and the amount you pay will differ depending upon the type of drugs purchased and whether they are obtained from a Participating Prescription Drug Provider.

[When you obtain generic drugs [(other than Specialty Drugs)]or generic diabetic supplies from a Participating Prescription Drug Provider, you must pay a Copayment amount of:

- **$**[1–200] **for each prescription** – for generic drugs and generic diabetic supplies and diabetic supplies.] 5.18a

When you obtain drugs [(other than Specialty Drugs)]or diabetic supplies from a Participating Prescription Drug Provider, benefits will be provided at:[

- [50–100]% **of the Eligible Charge for each prescription** – for generic drugs and generic diabetic supplies and diabetic supplies.] 5.18b
- [50–100]% **of the Eligible Charge for each prescription** – for Formulary brand name drugs and Formulary brand name diabetic supplies.
- [50–100]% **of the Eligible Charge for each prescription** – for non-Formulary brand name drugs and non-Formulary brand name diabetic supplies. **Revised 5/08**

[When you obtain Specialty Drugs from a Participating Prescription Drug Provider, benefits will be provided at [50–100]**% of the Eligible Charge for each prescription**.] 5.181 **New 5/08**

[When you obtain drugs or diabetic supplies [(other than generic drugs or generic diabetic supplies)]from a Participating Prescription Drug Provider, you will be responsible for the remaining Eligible Charge[up to a maximum of $[1–600] per prescription].[The minimum amount of your Coinsurance will be $[1–200] per prescription.]] 5.18b2

[When you obtain drugs or diabetic supplies [(other than generic drugs or generic diabetic supplies)]from a Participating Prescription Drug Provider, you will be responsible for the remaining Eligible Charge[up to a **maximum** of:[5.18b1 **New 5/08**

- $[1–600] per prescription for generic drugs[(other than Specialty Drugs)] and generic diabetic supplies.]
- $[1–600] per prescription for Formulary brand name drugs[(other than Specialty Drugs)] and Formulary brand name diabetic supplies.
- $[1–600] per prescription for non-Formulary brand name drugs[(other than Specialty Drugs)] and non-Formulary brand name diabetic supplies.]
- $[1–600] per prescription for Specialty Drugs.]]

[The **minimum** amount of your Coinsurance will be:[

- $[1–600] per prescription for generic drugs[(other than Specialty Drugs)] and generic diabetic supplies.]
- $[1–600] per prescription for Formulary brand name drugs[(other than Specialty Drugs)] and Formulary brand name diabetic supplies.
- $[1–600] per prescription for non-Formulary brand name drugs[(other than Specialty Drugs)] and non-Formulary brand name diabetic supplies.[
- $[1–600] per prescription for Specialty Drugs].]

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 Home Delivery Prescription Drug Program. For information on these drugs, contact your Participating Prescription Drug Provider or your local Blue Cross and Blue Shield office. Benefits for prescription inhalants will not be restricted on the number of days before an inhaler refill may be obtained.

When you obtain drugs or diabetic supplies from a non-Participating Prescription Drug Provider (other than a Participating Prescription Drug Provider), benefits will be provided at [50–100]75% of the amount you would have received had you obtained drugs from a Participating Prescription Drug Provider.[When you are responsible for a Copayment, [50–100]75% of the Eligible Charge will be paid minus the Copayment.]] 5.18

[**Benefit Payment for Prescription Drugs**

The benefits you receive and the amount you pay will differ depending upon the type of drugs purchased and whether they are obtained from a Participating Prescription Drug Provider.

[When you obtain generic drugs [(other than Specialty Drugs)]or generic diabetic supplies from a Participating Prescription Drug Provider, you must pay a Copayment amount of:

- **$**[1–200] **for each prescription** – for generic drugs and generic diabetic supplies and diabetic supplies.] 5.32a

When you obtain drugs [(other than Specialty Drugs)]or diabetic supplies from a Participating Prescription Drug Provider, benefits will be provided at:[

- [50–100]**% of the Eligible Charge for each prescription** – for generic drugs and generic diabetic supplies and diabetic supplies.] 5.32b
- [50–100]**% of the Eligible Charge for each prescription** – for Formulary brand name drugs and Formulary brand name diabetic supplies.
- [50–100]**% of the Eligible Charge for each prescription** – for non-Formulary brand name drugs and non-Formulary brand name diabetic supplies for which **there is no generic** drug or supply available.
- [If your Physician indicates dispense as written on the prescription, benefits will be provided at the payment level specified above and the following provision will not apply. 5.321

  ][50–100]**% of the Eligible Charge, minus the cost difference between the generic and brand name drugs or supplies, as determined by Blue Cross and Blue Shield, for each prescription** – for non-Formulary brand name drugs and non-Formulary brand name diabetic supplies for which **there is a generic** drug or supply available.

[When you obtain Specialty Drugs from a Participating Prescription Drug Provider, benefits will be provided at [50–100]**% of the Eligible Charge for each prescription**.] 5.322 **New 5/08**

[When you obtain drugs or diabetic supplies [(other than generic drugs or generic diabetic supplies)]from a Participating Prescription Drug Provider, you will be responsible for the remaining Eligible Charge[up to a maximum of $[1–600] per prescription].[The minimum amount of your Coinsurance will be $[1–200] per prescription.] 5.34

[When you obtain drugs or diabetic supplies [(other than generic drugs or generic diabetic supplies)]from a Participating Prescription Drug Provider, you will be responsible for the remaining Eligible Charge[up to a maximum of:[5.32b1 **New 5/08**

- $[1–600] per prescription for generic drugs[(other than Specialty Drugs)] and generic diabetic supplies.]
- $[1–600] per prescription for Formulary brand name drugs[(other than Specialty Drugs)]and Formulary brand name diabetic supplies.
- $[1–600] per prescription for non-Formulary brand name drugs[(other than Specialty Drugs)]and non-Formulary brand name diabetic supplies.[
- $[1–600] per prescription for Specialty Drugs.]]

[The minimum amount of your Coinsurance will be:[

- $[1–600] per prescription for generic drugs[(other than Specialty Drugs)] and generic diabetic supplies.]
- $[1–600] per prescription for Formulary brand name drugs[(other than Specialty Drugs)]and Formulary brand name diabetic supplies.
- $[1–600] per prescription for non-Formulary brand name drugs[(other than Specialty Drugs)]and non-Formulary brand name diabetic supplies.[

- $[1–600] per prescription for Specialty Drugs.]]

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 Home Delivery Prescription Drug Program. For information on these drugs, contact your Participating Prescription Drug Provider or your local Blue Cross and Blue Shield office. Benefits for prescription inhalants will not be restricted on the number of days before an inhaler refill may be obtained.

When you obtain drugs or diabetic supplies from a non-Participating Prescription Drug Provider (other than a Participating Prescription Drug Provider), benefits will be provided at [50–100]75% of the amount you would have received had you obtained drugs from a Participating Prescription Drug Provider.[When you are responsible for a Copayment, [50–100]75% of the Eligible Charge will be paid minus the Copayment.]] 5.32 **Revised 5/08**

[**Home Delivery Prescription Drug Program**

In addition to the benefits described in this Benefit Section, your coverage includes benefits for maintenance type drugs and diabetic supplies obtained through the Home Delivery Prescription Drug Program. For information about this program, contact your employer or Group Administrator.] **Revised 5/08** 5.8

[When you obtain drugs [(other than Specialty Drugs)]or diabetic supplies through the Home Delivery Prescription Drug Program, you must pay a Copayment amount of $[1–600] for each prescription.] 5.9

[When you obtain Specialty Drugs from a Participating Prescription Drug Provider, you must pay a Copayment amount of **$**[1–200] **for each prescription**.] 5.91 **New 5/08**

[When you obtain drugs [(other than Specialty Drugs)]or diabetic supplies through the Home Delivery Prescription Drug Program, you must pay a Copayment amount of:

- **$**[1–600] **for each prescription** – for generic drugs and generic diabetic supplies[or brand name drugs[(other than self-injectable drugs)] and brand name diabetic supplies][for which there is no generic drug or supply available]. 5.13
- **$**[1–600] **for each prescription** – for brand name drugs[(other than self-injectable drugs)] and brand name diabetic supplies.][5.10
- **$**[1–600] **for each prescription** – for self-injectable drugs other than insulin.] 5.12

[When you obtain Specialty Drugs from a Participating Prescription Drug Provider, you must pay a Copayment amount of **$**[1–200] **for each prescription**.] 5.101 **New 5/08**

[When you obtain drugs [(other than Specialty Drugs)]or diabetic supplies through the Home Delivery Prescription Drug Program, you must pay a Copayment amount of:

- **$**[1–600] **for each prescription** – for generic drugs and generic diabetic supplies.
- **$**[1–600] **for each prescription** – for Formulary brand name drugs and Formulary brand name diabetic supplies.
- **$**[1–600] **for each prescription** – for non-Formulary brand name drugs and non-Formulary brand name diabetic supplies. 5.15
- **$**[1–600] **for each prescription** – for self-injectable drugs other than insulin[and infertility drugs].] 5.151

[When you obtain Specialty Drugs from a Participating Prescription Drug Provider, you must pay a Copayment amount of **$**[1–200] **for each prescription**.] 5.152 **New 5/08**

[When you obtain drugs [(other than Specialty Drugs)]or diabetic supplies through the Home Delivery Prescription Drug Program, you must pay a Copayment amount of:

- **$**[1–600] **for each prescription** – for generic drugs and generic diabetic supplies.
- **$**[1–600] **for each prescription** – for Formulary brand name drugs and Formulary brand name diabetic supplies.
- **$**[1–600] **for each prescription** – for non-Formulary brand name drugs and non-Formulary brand name diabetic supplies for which **there is no generic** drug or supply available.
- [If your Physician indicates dispense as written on the prescription, you will be responsible for the Copayment amount specified above and the following provision will not apply. 5.311

  ]**$**[1–600]**, plus the cost difference between the generic and brand name drugs or supplies, as determined by Blue Cross and Blue Shield, for each prescription** – for non-Formulary brand name drugs and non-Formulary brand name diabetic supplies for which **there is a generic** available.] 5.311

[When you obtain Specialty Drugs from a Participating Prescription Drug Provider, you must pay a Copayment amount of **$**[1–200] **for each prescription**.] 5.312 **New 5/08**

[When you obtain drugs [(other than Specialty Drugs)]or diabetic supplies through the Home Delivery Prescription Drug Program, you must pay a Copayment amount of:

- **$**[1–600] **for each prescription** – for generic drugs and generic diabetic supplies.
- **$**[1–600] **for each prescription** – for brand name drugs and brand name diabetic supplies for which **there is no generic** drug or supply available.
- **$**[1–600] **for each prescription** – for brand name drugs and brand name diabetic supplies for which **there is a generic** drug or supply available.] 5.17

[When you obtain Specialty Drugs from a Participating Prescription Drug Provider, you must pay a Copayment amount of **$**[1–200] **for each prescription**.] 5.171 **New 5/08**

[When you obtain drugs [(other than Specialty Drugs)]or diabetic supplies through the Home Delivery Prescription Drug Program, you must pay a Copayment amount of:

- **$**[1–600] **for each prescription** – for generic drugs and generic diabetic supplies.
- **$**[1–600] **for each prescription** – for brand name drugs and brand name diabetic supplies for which **there is no generic** drug or supply available**.**
- [If your Physician indicates dispense as written on the prescription, you will be responsible for the Copayment amount specified above and the following provision will not apply. 5.291

  ]**$**[1–600]**, plus the cost difference between the generic and brand name drugs or supplies, as determined by Blue Cross and Blue Shield, for each**

prescription – for brand name drugs and brand name diabetic supplies for which **there is a generic** drug or supply available.] 5.29

[When you obtain Specialty Drugs from a Participating Prescription Drug Provider, you must pay a Copayment amount of **$**[1–200] **for each prescription**.] 5.292 **New 5/08**

[When you obtain generic drugs [(other than Specialty Drugs)]or generic diabetic supplies through the Home Delivery Prescription Drug Program, you must pay a Copayment amount of:

- **$**[1–600] **for each prescription** – for generic drugs and generic diabetic supplies.] 5.19a

[When you obtain drugs [(other than Specialty Drugs)]or diabetic supplies through the Home Delivery Prescription Drug Program, benefits will be provided at [50–100]% of the Eligible Charge for each prescription.] 5.45

[When you obtain Specialty Drugs from a Participating Prescription Drug Provider, benefits will be provided at [50–100]**% of the Eligible Charge for each prescription**.] 5.451 **New 5/08**

[When you obtain drugs [(other than Specialty Drugs)]or diabetic supplies through the Home Delivery Prescription Drug Program, benefits will be provided at:

- [50–100]% **of the Eligible Charge for each prescription** – for generic drugs and generic diabetic supplies.] 5.19b
- [50–100]% **of the Eligible Charge for each prescription** – for Formulary brand name drugs and Formulary brand name diabetic supplies.
- [50–100]% **of the Eligible Charge for each prescription** – for non-Formulary brand name drugs and non-Formulary brand name diabetic supplies.] 5.19

[When you obtain Specialty Drugs from a Participating Prescription Drug Provider, benefits will be provided at [50–100]**% of the Eligible Charge for each prescription**.] 5.191 **New 5/08**

[When you obtain generic drugs [(other than Specialty Drugs)]or generic diabetic supplies through the Home Delivery Prescription Drug Program, you must pay a Copayment amount of:

- **$**[1–600] **for each prescription** – for generic drugs and generic diabetic supplies.] 5.33a

[When you obtain drugs [(other than Specialty Drugs)]or diabetic supplies through the Home Delivery Prescription Drug Program, benefits will be provided at:[

- [50–100]**% of the Eligible Charge for each prescription** – for generic drugs and generic diabetic supplies.] 5.33b
- [50–100]**% of the Eligible Charge for each prescription** – for Formulary brand name drugs and Formulary brand name diabetic supplies.
- [50–100]**% of the Eligible Charge for each prescription** – for non-Formulary brand name drugs and non-Formulary brand name diabetic supplies for which **there is no generic** drug or supply available.
- [If your Physician indicates dispense as written on the prescription, benefits will be provided at the payment level specified above and the following provision

will not apply. 5.331

][50–100]**% of the Eligible Charge, minus the cost difference between the generic and brand name drugs or supplies, as determined by Blue Cross and Blue Shield, for each prescription** – for non-Formulary brand name drugs and non-Formulary brand name supplies for which **there is a generic** drug or supply available.] 5.33

[When you obtain Specialty Drugs from a Participating Prescription Drug Provider, benefits will be provided at [50–100]**% of the Eligible Charge for each prescription**.] 5.332 **New 5/08**

[When you obtain drugs or diabetic supplies [(other than generic drugs or generic diabetic supplies)]through the Home Delivery Prescription Drug Program, you will be responsible for the remaining Eligible Charge[up to a maximum of $[1–600] per 3 month prescription].[The minimum amount of your Coinsurance will be $[1–200] for a 3 month prescription.]] 5.27

[When you obtain drugs or diabetic supplies [(other than generic drugs or generic diabetic supplies)]from a Participating Prescription Drug Provider, you will be responsible for the remaining Eligible Charge[up to a **maximum** of:[5.33b1 **New 5/08**

- $[1–600] per prescription for generic drugs [(other than Specialty Drugs)]and generic diabetic supplies.]
- $[1–600] per prescription for Formulary brand name drugs [(other than Specialty Drugs)]and Formulary brand name diabetic supplies.
- $[1–600] per prescription for non-Formulary brand name drugs [(other than Specialty Drugs)]and non-Formulary brand name diabetic supplies.[
- $[1–600] per prescription for Specialty Drugs.]]

[The **minimum** amount of your Coinsurance will be:[

- $[1–600] per prescription for generic drugs [(other than Specialty Drugs)]and generic diabetic supplies.]
- $[1–600] per prescription for Formulary brand name drugs [(other than Specialty Drugs)]and Formulary brand name diabetic supplies.
- $[1–600] per prescription for non-Formulary brand name drugs [(other than Specialty Drugs)]and non-Formulary brand name diabetic supplies.[
- $[1–600] per prescription for Specialty Drugs.]]

SUPPLEMENTAL ACCIDENT CARE BENEFIT SECTION

In the other Benefit Sections of this Certificate, your benefits for Emergency Accident Care were explained. In addition to those benefits, your coverage also provides you with benefits for certain other services that you might receive as the result of an accident. These additional benefits are called Supplemental Accident Care Benefits and this section describes the Supplemental Accident Care Services and the benefits that are available for them.

The benefits of this section are subject to all of the terms and conditions of this Certificate. Please refer to the DEFINITIONS, ELIGIBILITY and EXCLUSIONS sections of this Certificate for additional information regarding any limitations and/or special conditions pertaining to your benefits.

For Supplemental Accident Care benefits to be available, the services must be Medically Necessary.

These Supplemental Accident Care benefits will not duplicate the coverage that you are entitled to under the Hospital and Physician Benefit Sections. Rather, these benefits will supplement that coverage. In other words, your benefits for Supplemental Accident Care will not begin until you have received benefits for the initial Outpatient visit of Emergency Accident Care.

The level of benefits paid for Hospital Covered Services is generally greater when received in a Plan Hospital or other Plan facility. 4.01

COVERED SERVICES

Your Supplemental Accident Care coverage will provide benefits for the following Covered Services as long as you receive these services within 90 days of the date of the accident and the services are received as a result of the accident.

1. Inpatient and Outpatient care in a Hospital.
2. Medical and surgical treatment by a Physician, Podiatrist or Chiropractor.
3. Diagnostic Services.
4. Private Duty Nursing Service.

Benefit Payment for Supplemental Accident Care

Benefits will be provided at 100% of the Eligible Charge or Usual and Customary Fee for Supplemental Accident Care Covered Services, up to a maximum of $ per accident (but only to the extent such Covered Services are not covered under the other Benefit Sections of this Certificate). 4.1

ACCIDENT CARE BENEFIT SECTION

Your coverage provides benefits for Emergency Accident Care and follow-up care as a result of an accident. This section describes your Accident Care Covered Services and the benefits that are available for them.

The benefits of this section are subject to all of the terms and conditions of this Certificate. Please refer to the DEFINITIONS, ELIGIBILITY AND EXCLUSIONS sections of this Certificate for additional information regarding any limitations and/or special conditions pertaining to your benefits.

Covered Services

Your coverage provides benefits for Emergency Accident Care and follow-up care as a result of an accident. Benefits will be provided for the following Covered Services as long as you receive these services within 90 days of the date of the accident and the services are received as a result of the accident. Benefits will be provided only if such Covered Services are Medically Necessary.

- Outpatient care in a Hospital
- Medical and surgical treatment by a Physician, Podiatrist or Chiropractor
- Diagnostic Services
- Private Duty Nursing

Benefit Payment for Accident Care

Benefits will be provided at 100% of the Eligible Charge or Usual and Customary Fee for Accident Care Covered Services, up to a maximum of $ per accident, thereafter benefits will be provided the same as any other condition according to the payment levels described in this Certificate. 28.1a

Benefits will be provided at 100% of the Eligible Charge or Maximum Allowance for Accident Care Covered Services, up to a maximum of $ per accident, thereafter benefits will be provided the same as any other condition according to the payment levels described in this Certificate. 28.1b

OUTPATIENT DIAGNOSTIC BENEFIT SECTION

Your coverage includes benefits for Diagnostic Service and mammograms when you receive them as an Outpatient from a Hospital or a Physician (or from a laboratory if your Physician has ordered that the tests be performed there).

The benefits of this section are subject to all of the terms and conditions of this Certificate.Your benefits are also subject to the Pre-Existing Conditions waiting period. Please refer to the DEFINITIONS, ELIGIBILITY and EXCLUSIONS sections of this Certificate for additional information regarding any limitations and/or special conditions pertaining to your benefits. 0.568

For Outpatient Diagnostic Service benefits to be available, it must be Medically Necessary and you must receive such service on or after your Coverage Date.

The level of benefits paid for Hospital Covered Services is generally greater when received in a Plan Hospital or other Plan facility. 3.01

Benefit Payment for Outpatient Diagnostic Service

When you receive Outpatient Diagnostic Services from a Plan Hospital, benefits will be provided at 100% of the Eligible Charge. If you receive these services from a Non-Plan Hospital, payment will be 50% of the Eligible Charge.

When you receive Outpatient Diagnostic Services from a Physician or one of the other Providers specified above benefits will be provided at 100% of the Usual and Customary Fee. 3.1a

When you receive Outpatient Diagnostic Services from a Plan Hospital, benefits will be provided at 100% of the Eligible Charge up to $ each calendar year. If you receive these services from a Non-Plan Hospital, payment will be 50% of the Eligible Charge.

When you receive Outpatient Diagnostic Services from a Physician or one of the other Providers specified above, benefits will be provided at 100% of the Usual and Customary Fee up to $ each calendar year. 3.1b

TREATMENT OF TEMPOROMANDIBULAR JOINT DYSFUNCTION AND RELATED DISORDERS BENEFIT SECTION

Your coverage includes benefits for all of the Covered Services previously described in this Certificate for the diagnosis and treatment of Temporomandibular Joint Dysfunction and Related Disorders.

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

Benefit Payment for the Diagnosis and/or Treatment of Temporomandibular Joint Dysfunction and Related Disorders

Your benefits for the diagnosis and treatment of Temporomandibular Joint Dysfunction and Related Disorders are the same as your benefits for any other condition. However, your benefits for the diagnosis and/or treatment of Temporomandibular Joint Dysfunction and Related Disorders are limited to a lifetime maximum of $. 1.30a
However, your benefits for the diagnosis and/or treatment of Temporomandibular Joint Dysfunction and Related Disorders are limited to a benefit period maximum of $500. 1.30b 1.30

INDIVIDUAL BENEFITS MANAGEMENT PROGRAM

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

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

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

Blue Cross and Blue Shield's election to provide alternative benefits in one instance shall not obligate it to provide the same or similar benefits for you in any other instance. In addition, Blue Cross and Blue Shield's offering or providing alternative benefits shall not be construed as a waiver of any of the terms, provisions, or conditions of limitations of this Certificate. 21.0

HOSPICE CARE PROGRAM

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

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

The following services are covered under the Hospice Care Program:

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

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.

Benefit Payment for Hospice Care Program Services

[Benefit payment for Covered Services rendered by a Hospice Care Program Provider will be provided at the same level as described for Inpatient Hospital Covered Services.] 32.02a

[Benefits for Covered Services rendered by a Hospice Care Program Provider will be provided at [50–100]% of the Eligible Charge[after you have met your program deductible].[When you receive Hospice Care Program Services as an Inpatient, your

Inpatient Hospital admission deductible will apply.][Your program deductible will not apply.]]	32.02b1	32.02b1a	32.02b1b	32.02b1c
[When you receive Hospice Care Program Services from a Non-Plan Provider, benefits will be provided at 50% of the Eligible Charge after you have met your program deductible.[When you receive Hospice Care Program Services as an Inpatient, your Inpatient Hospital admission deductible will apply.]]	32.02b3	32.02b3b		
[When you receive Hospice Care Program Services from a Non-Plan Provider, benefit payment will be 80% of the amount you would have received had these services been received from a Plan Provider.]	32.02b4			
[Benefits for Hospice Care Program Services will be provided at [50–100]% of the Eligible Charge when Covered Services are rendered by a Participating Provider[, after you have met your program deductible].[When you receive Hospice Care Program Services as an Inpatient, your Inpatient Hospital admission deductible will apply.][Your program deductible will not apply.]]				
[When Hospice Care Program Services are rendered by a Non-Participating Provider, benefits will be provided at [50–100]% of the Eligible Charge[, after you have met your program deductible].[When you receive Hospice Care Program Services as an Inpatient, your Inpatient Hospital admission deductible will apply.][Your program deductible will not apply.]]	32.02b2	32.02b2b		
[When you receive Hospice Care Program Services from a Non-Plan Provider, benefits will be provided at 50% of the Eligible Charge after you have met your program deductible.][When you receive Hospice Care Program Services as an Inpatient, your Inpatient Hospital admission deductible will apply.]]	32.02c5	32.02c5a		
[When you receive Hospice Care Program Services from a Non-Plan Provider, benefits will be provided at the same payment level which would have been paid had such services been received from a Non-Participating Provider.]	32.02c6			
[Your benefits under the Hospice Care Program are limited to a lifetime maximum of $[500–100,000].]	32.01			

MANDATORY OUTPATIENT SURGERY PROGRAM

The following surgical procedures must be performed on an Outpatient basis. Benefits for these surgical procedures and related services will be provided at 100 % of the Eligible Charge and 100 % of the Usual and Customary Fee when these procedures are performed in a Plan Hospital, Plan Ambulatory Surgical Facility or in a Physician's office. If performed in a Non–Plan facility, benefits will be provided at the Non–Plan levels described in this Certificate. 2.201

Abdominal paracentesis
Antrum irrigations
Arthrocentesis
Arthrography and arthroscopy
Aspiration of Douglas's cul–de–sac
Bartholin cyst excision, marsupialization or I&D
Bladder puncture aspiration
Blepharoplasty, non–cosmetic
Breast biopsy
Bronchoscopy with or without biopsy
Carpal Tunnel Decompression
Cataract Extraction
Cervical biopsies or polypectomies, except cold conization
Circumcision, other than newborn
Closed reduction of complete dislocations or fractures
Culdoscopy with or without biopsy
Cyst aspiration, superficial
Cystogram
Cystoscopy with or without retrograde pyelogram
Dilation and Curettage, diagnostic and therapeutic
Digit amputation, revision of
Dorsal split of prepuce
Esophageal dilation
EUA (examination under anesthesia)
Excision of soft tissue lesions (nevus, verrucous, epithelioma, scar revision)
Fiberoptic endoscopy with or without biopsy
Foreign body removal of unnatural material from hands or feet
Frenulotomy of tongue
Ganglionectomy
Gastroscopy with or without biopsy
Herniorrhaphy (up to age 14)
Hydrocelectomy
Hymenectomy
Hysterosalpingography
I&D (incision and drainage of superficial lesions)
Injection of joint, tendon or ligament
IUD insertion and removal, if anesthesia necessary
Laceration, suture of skin and tendons
Laparoscopy with or without tubal ligation
Laryngoscopy with or without biopsy

Lipoma removal
Meatotomy
Minor eyelid procedures
Minor rectal Surgery (not under spinal)
Muscle biopsy
Myringotomy
Nasal fracture reduction, open and closed
Nasal polypectomy
Nerve blocks
Node biopsy (superficial)
Otoplasty, non–cosmetic
Otoscopy with or without biopsy
Pin and screw removals from hand or forearm
Proctosigmoidoscopy with or without biopsy
Septoplasty
Skin biopsy
Skin graft (small)
Submucous resection of nasal septum
Synovial cyst removal
Tear duct probing
Thoracocentesis for fluid aspiration
Trigger finger
Triple upper endoscopy
Urethral dilation
Varicocelectomy
Vasectomy
Vein sclerosing injection
Venography

No benefits will be provided under any of the benefit sections of this Certificate for the above surgical procedures and related services if performed on an Inpatient basis, unless you submit medical documentation which substantiates, in the reasonable judgment of Blue Cross and Blue Shield, that performing the particular surgical procedure on an Inpatient basis was Medically Necessary. If acceptable documentation is submitted, benefits for the Inpatient Hospital and Surgery Services will be provided at the regular payment levels described in this Certificate.

MEDICARE ELIGIBLE MEMBERS

The provisions of this Mandatory Outpatient Surgery Program do not apply to you if you are Medicare Eligible and have secondary coverage provided under this Certificate.

MANDATORY ADDITIONAL SURGICAL OPINION PROGRAM

When Surgery is recommended by your Physician for one of the elective surgical procedures listed below, you must obtain an additional surgical opinion prior to Surgery in order to receive full payment of benefits. If an additional surgical opinion is not obtained, Hospital and Surgery benefits will be provided at 50 % of the amounts which would have been paid had you obtained an additional surgical opinion. The additional surgical opinion will remain valid for 90 days after it has been obtained. If your Surgery does not occur within this 90–day period, a second additional surgical opinion must be obtained. 2.101

The elective surgical procedures are as follows:

Arthrotomy for Lateral and/or Medial Meniscus Disorders
Bunionectomy
Cataract Extraction
Coronary Artery Bypass
Cystocele Rectocele Repair
Dilation and Curettage
Elective Cholecystectomy
Hammer Toe
Hernia Repair (Inguinal Hernia Repair)
Hysterectomy
Laminectomy
Submucous Resection of Nasal Septum
Tonsillectomy and Adenoidectomy
Transurethral Prostatectomy for Benign Hyperplasia

In order to obtain an additional surgical opinion, you must contact the Additional Surgical Opinion Referral Center. The Center will furnish you with the names of three Physicians with whom Blue Cross and Blue Shield has an agreement to render surgical opinions. You may select one of these Physicians for your consultation. However, you may also select any other Physician who has an agreement with Blue Cross and Blue Shield to render surgical opinions.

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

No reduction of benefits as a result of the Mandatory Additional Surgical Opinion provisions of this Certificate will be eligible for consideration under any other benefit section or included in the calculation of the out–of–pocket expense for Major Medical Covered Services described in the Major Medical Benefit Section of this Certificate. 2.102

Benefit Payment for the Additional Surgical Opinion

Benefits for the additional surgical opinion will be provided at 100% of the Usual and Customary Fee, whether or not you have met your deductible (if applicable to this Certificate). In addition to the consultation, benefits will also include related Diagnostic Service required by the consulting Physician.

Upon your request, benefits will be provided for an additional consultation when the need for Surgery, in your opinion, is not resolved by the first arranged consultation.

MEDICARE ELIGIBLE MEMBERS

The provisions of this Mandatory Additional Surgical Opinion Program do not apply to you if you are Medicare Eligible and have secondary coverage provided under this Certificate.

VISION CARE PROGRAM

Your coverage includes benefits for vision care when you receive such care from a Physician, Optometrist or Optician.

The benefits of this section are subject to all of the terms and conditions of this Certificate. Please refer to the DEFINITIONS, ELIGIBILITY and EXCLUSIONS sections of this Certificate for additional information regarding any limitations and/or special conditions pertaining to your benefits.

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

In addition to the Definitions of this Certificate, the following definitions are applicable to this Benefit Section:

CONTACT LENSES.....means ophthalmic corrective lenses, either glass or plastic, ground or molded to be fitted directly on your eye.

FRAME.....means a standard eyeglass frame adequate to hold Lenses.

LENSES.....means ophthalmic corrective lenses, either glass or plastic, ground or molded to improve visual acuity and to be fitted to a Frame.

OPTICIAN.....means a duly licensed optician.

Benefit Period

Your vision care benefit period begins on the first date a Covered Service is received after your Coverage Date and continues for a period of consecutive months thereafter. Later benefit periods will begin on the first date a Covered Service is received following the expiration of your prior benefit period. 18.1a

Your vision care benefit period is a period of one year which begins on January 1st of each year. When you first enroll under this coverage, your first benefit period begins on your Coverage Date, and ends on the first December 31st following that date. 18.1b

Your vision care benefit period is a period of one year which begins on of each year. When your first enroll under this coverage, your first benefit period begins on your Coverage Date but ends on the date it would normally end. 18.1c

Covered Services

Benefits will be provided under this Benefit Section for the following:

Single Vision Lenses
Bifocal Lenses
Trifocal Lenses
Lenticular Lenses
Contact Lenses
Frames

You are entitled to receive one of the Covered Services above each benefit period. In addition, benefits will be provided for vision examination(s) each benefit period. However, additional benefits will be provided within the benefit period if a prescription change is required from previous Lenses covered under this vision care program.

No additional benefits will be provided for tinted, photo-sensitive or anti-reflective Lenses above the benefit allowance for regular Lenses. 18.2

Special Limitations

Benefits will not be provided for the following:

1. Recreational sunglasses
2. Medical or surgical treatment
3. Drugs or any medication not administered for the purpose of a vision testing examination.
4. Orthoptics, vision training, subnormal vision aids, aniseikonic Lenses and tonography.
5. Replacement of Lenses or Frames which are lost or broken.

Benefit Payment for Vision Care

Benefits for vision care Covered Services will be provided at % of the Usual and Customary Fee, limited to $ per benefit period. The allowance for appropriate spectacle type Lenses with Frame will be made for Contact Lenses unless the visual acuity cannot be made 20/70 or better with spectacle Lenses, but can be so improved with Contact Lenses.

For purposes of this Benefit Section only, the definition of Usual and Customary Fee shall read as follows:

USUAL AND CUSTOMARY FEE.....means the fee as reasonably determined by Blue Cross and Blue Shield, which is based on the fee which the Physician, Optician or Optometrist who renders the particular service usually charges his patients or customers for the same service and the fee which is within the range of fees other Physicians, Opticians or Optometrists of similar training and experience in the same geographic area charge their patients or customers for the same service, under similar or comparable circumstances. 18.30

Benefits for vision care Covered Service will be provided at the payment levels listed below.

Vision Examination	$16 per exam
Single Vision Lenses	$14 per pair
Bifocal Lenses	$25 per pair
Trifocal Lenses	$35 per pair
Lenticular Lenses	$70 per pair
Contact Lenses*	$70 per pair
Frames	$14 per Frame

18.311

*The allowance for the appropriate spectacle type Lenses with Frame will be made for Contact Lenses unless the visual acuity cannot be made 20/70 or better with spectacle Lenses, but can be so improved with Contact Lenses. 18.31

Vision Examination	$ 25 per exam
Single Vision Lenses	$ 20 per pair

Bifocal Lenses	$ 35 per pair	
Trifocal Lenses	$ 40 per pair	
Lenticular Lenses	$100 per pair	
Contact Lenses*	$100 per pair	
Frames	$ 20 per Frame	18.312

*The allowance for the appropriate spectacle type Lenses with Frame will be made for Contact Lenses unless the visual acuity cannot be made 20/70 or better with spectacle Lenses, but can be so improved with Contact Lenses. 18.31

Vision Examination	$ 32 per exam	
Single Vision Lenses	$ 28 per pair	
Bifocal Lenses	$ 50 per pair	
Trifocal Lenses	$ 70 per pair	
Lenticular Lenses	$140 per pair	
Contact Lenses*	$140 per pair	
Frames	$ 28 per Frame	18.313

*The allowance for the appropriate spectacle type Lenses with Frame will be made for Contact Lenses unless the visual acuity cannot be made 20/70 or better with spectacle Lenses, but can be so improved with Contact Lenses. 18.31

Benefits for vision care Covered Service will be provided at the payment levels listed below.

Vision Examination	$ per exam
Single Vision Lenses	$ per pair
Bifocal Lenses	$ per pair
Trifocal Lenses	$ per pair
Lenticular Lenses	$ per pair
Lenses (other than Contact Lenses)	$ per pair
Contact Lenses*	$ per pair
Frames	$ per Frame

*The allowance for the appropriate spectacle type Lenses with Frame will be made for Contact Lenses unless the visual acuity cannot be made 20/70 or better with spectacle Lenses, but can be so improved with Contact Lenses. 18.41

HEARING CARE PROGRAM

Your coverage includes benefits for hearing care when you receive such care from a Physician, Otologist, Audiologist or Hearing Aid Dealer.

The benefits of this section are subject to all of the terms and conditions of this Certificate. Please refer to the DEFINITIONS, ELIGIBILITY and EXCLUSIONS sections of this Certificate for additional information regarding any limitations and/or special conditions pertaining to your benefits.

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

In addition to the Definitions of this Certificate, the following definitions are applicable to this Benefit Section:

AUDIOLOGIST.....means a duly licensed audiologist.

HEARING AID DEALER.....means a Provider licensed to make and provide hearing aids to you.

OTOLOGIST.....means a duly licensed otologist or otolaryngologist.

Benefit Period

Your hearing care benefit period begins on the first date a Covered Service is received after your Coverage Date and continues for a period of consecutive months thereafter. Later benefit periods will begin on the first date a Covered Service is received following the expiration of your prior benefit period. 19.1a

Your hearing care benefit period is a period of one year which begins on January 1st of each year. When you first enroll under this coverage, your first benefit period begins on your Coverage Date, and ends on the first December 31st following that date. 19.1b

Your hearing care benefit period is a period of one year which begins on of each year. When your first enroll under this coverage, your first benefit period begins on your Coverage Date but ends on the date it would normally end. 19.1c

Covered Services

Benefits will be provided under this Benefit Section for the following:

Audiometric Examination
Hearing Aid Evaluation
Conformity Evaluation
Hearing Aids

Benefits will be limited to Covered Service(s) of each type listed above per benefit period. 19.2

Special Limitations

Benefits will not be provided for the following:

1. Audiometric examinations by an Audiologist when not ordered by your Physician within 6 months of such examination.
2. Medical or surgical treatment.

3. Drugs or other medications.
4. Replacement for lost or broken hearing aids, except if otherwise eligible under frequency limitations.
5. Hearing aids ordered while covered but delivered more than 60 days after termination.

Benefit Payment for Hearing Care

Benefits for hearing care Covered Services will be provided at % of the Usual and Customary Fee, limited to $ per benefit period. 19.30 19.30a

Benefits for hearing aids will be provided up to a lifetime maximum of $. 19.30b

For purposes of this Benefit Section only, the definition of Usual and Customary Fee shall read as follows:

USUAL AND CUSTOMARY FEE .....means the fee as reasonably determined by Blue Cross and Blue Shield, which is based on the fee which the Physician, Otologist, Audiologist or Hearing Aid Dealer who renders the particular service usually charges his patients or customers for the same service and the fee which is within the range of usual fees other Physicians, Otologists, Audiologists or Hearing Aid Dealers of similar training and experience in the same geographic area charge their patients or customers for the same service, under similar or comparable circumstances. 19.30

Benefits for hearing care Covered Services will be provided at the payment levels listed below.

	Indemnity 1	
Audiometric Exam		
• By a physician	$ 12	
• By an audiologist	$ 10	
Hearing Aid Evaluation	$ 10	
Conformity Evaluation	$ 3	
Hearing Aids		
• On-the-body	$120	
• In-the-ear	$115	
• Behind-the-ear	$125	
• Eyeglass type*	$125	19.311

	Indemnity 2
Audiometric Exam	
• By a physician	$ 17
• By an audiologist	$ 15
Hearing Aid Evaluation	$ 15
Conformity Evaluation	$ 5
Hearing Aids	

• On-the-body	$170	
• In-the-ear	$160	
• Behind-the-ear	$180	
• Eyeglass type*	$180	19.312

Indemnity 3

Audiometric Exam		
• By a physician	$ 24	
• By an audiologist	$ 21	
Hearing Aid Evaluation	$ 21	
Conformity Evaluation	$ 7	
Hearing Aids		
• On-the-body	$240	
• In-the-ear	$225	
• Behind-the-ear	$255	
• Eyeglass type*	$255	19.313

*No benefits will be provided for Eyeglass type hearing aids to the extent that they exceed the cost of the other approved types.

Benefits for hearing care Covered Services will be provided at the payment levels listed below.

Indemnity Schedule

Audiometric Exam		
• By a physician	$	
• By an audiologist	$	
Hearing Aid Evaluation	$	
Conformity Evaluation	$	
Hearing Aids		
• On-the-body	$	
• In-the-ear	$	
• Behind-the-ear	$	
• Eyeglass type*	$	19.411

*No benefits will be provided for Eyeglass type hearing aids to the extent that they exceed the cost of the other approved types.

DENTAL BENEFIT SECTION

An important part of proper health care is maintaining good dental health. Your benefit program includes coverage for dental services and this section of your Certificate explains what dental services are covered and how much will be paid for them.

The benefits of this section are subject to all of the terms and conditions of this Certificate. Please refer to the DEFINITIONS, ELIGIBILITY and EXCLUSIONS sections of this Certificate for additional information regarding any limitations and/or special conditions pertaining to your benefits.

For benefits to be available, dental services must be Medically Necessary and rendered and billed for by a Dentist or Physician, unless otherwise specified. No payment will be made by Blue Cross and Blue Shield until after receipt of a Dentist's or Physician's Claim form. In addition, benefits will be provided only if services are rendered on or after your Coverage Date.

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

COVERED SERVICES

Your Dental Benefits include coverage for the following Covered Services as long as these services are rendered to you by a Dentist or a Physician. When the term "Dentist" is used in this Benefit Section, it will mean Dentist or Physician.

Preventive Dental Services

Your Preventive Dental benefits are designed to help you keep dental disease from starting or to detect it in its early stages. Your Preventive Dental Services are as follows:

- Oral Examinations—The initial oral examination and periodic routine oral examinations. However, your benefits are limited to two examinations every benefit period.
- Prophylaxis—The routine scaling and polishing of your teeth. However, your benefits are limited to two cleanings each benefit period.
- Topical Fluoride Application—Benefits for this application are only available to dependent children under age 19 and are limited to two applications each benefit period.
- Dental X-rays—Benefits for routine X-rays are limited to one full mouth X-ray and additional bitewing X-rays every twelve months. 7.11
- Space Maintainers—Benefits for space maintainers are only available to dependent children under age 19 and not when part of orthodontic treatment. 7.12
- Emergency oral examinations and palliative emergency treatment for the temporary relief of pain.
- Sealants—Benefits for sealants are only available to dependent children under age 19. 7.13

Primary Dental Services

Your Primary Dental benefits cover a wide range of services that can help you maintain continued good dental health. These services are as follows:

- Dental X-rays—Benefits for routine X-rays are limited to one full mouth X-ray and additional bitewing X-rays every twelve months. 7.21a
- Dental X-rays—Benefits for routine X-rays are limited to one full mouth X-ray and additional bitewing X-rays every thirty-six months. 7.21b
- Fillings
- Extractions, except as specifically excluded under ‘‘Special Limitations’’ of this Benefit Section.
- Oral Surgery, except as specifically excluded under ‘‘Special Limitations’’ of this Benefit Section.
- Endodontics
- Pulp Vitality Tests—Benefits for these tests are limited to once every twelve months.
- Apicoectomies
- Hemisection
- Biopsies of Oral Tissue
- Periodontics/Periodontal Therapy

  Gingivectomy and gingivoplasty; gingival curettage; periodontal scaling and root planing; osseous Surgery; and mucogingival Surgery. Your benefits are limited to one full mouth treatment per benefit period.

  Periodontal maintenance procedures — Benefits for periodontal maintenance procedures are limited to four per benefit period, however, this maximum will be reduced by any routine prophylaxes in the same benefit period. In addition, you must have received periodontal therapy before benefits for these procedures will be provided.
- Stainless Steel Crowns
- Repair of Removable Dentures
- Recementing of Crowns, Inlays, Onlays and Bridges
- Space Maintainers—Benefits for space maintainers are only available to dependent children under age 19 and not when part of orthodontic treatment. 7.23
- General Anesthesia/Intravenous Sedation—If Medically Necessary and administered with a covered dental procedure. The anesthesia must be given by a person who is licensed to administer general anesthesia/intravenous sedation.
- Home Visits—Visits by a Dentist to your home when medically required to render a covered dental service.
- Sealants—Benefits for sealants are only available to dependent children under age 19. 7.14

Major Dental Services

Your Major Dental Benefits are designed to help you pay for certain types of more extensive dental services. These services are as follows:

- Inlays, Onlays and Crowns (other than temporary crowns and stainless steel crowns)
- Fixed Bridgework
- Bridge Repairs
- Full and Partial Dentures
- Denture Adjustments, Rebasing and Relining—During the first six months after obtaining dentures or having them relined, adjustments are covered only if they are done by someone other than the Dentist or his in-office associates who provided or relined the dentures.

Once you receive benefits for a crown, inlay, onlay, bridge or denture, replacements are not covered until 5 years have elapsed. Also, benefits are not available for the replacement of a bridge or denture which could have been made serviceable. 7.3

Orthodontic Dental Services

Your Dental Benefits include coverage for orthodontic appliances and treatments when they are being provided to correct problems of growth and development. These benefits are subject to the lifetime maximum and limited as follows:

- Benefits are only available for dependent children under age 19 and will end on their birthday. 7.41
- Diagnostic benefits, including examination, study models, X-rays and all other diagnostic aids, will be provided only once in any 5 year period, beginning with the date of the first visit to the Dentist.
- Benefits for active orthodontic treatment are limited to 36 consecutive months of treatment and benefits for retention treatment are limited to 10 visits. If you are receiving treatment when your coverage begins, these time periods will be reduced by the number of months that you have been receiving treatment prior to your coverage beginning.
- Benefits will not be provided for the replacement or repair of any appliance used during orthodontic treatment.
- After your orthodontic treatment has been completed, no further orthodontic benefits will be provided until 5 years have elapsed. However, benefits will be available only if you have not reached your lifetime maximum. 7.4

BENEFIT PAYMENT FOR DENTAL COVERED SERVICES

Benefit Period

Your Dental benefit period is a period of one year which begins on January 1st of each year. When you first enroll under this coverage, your first benefit period begins on your Coverage Date but ends on the date it would normally end. 7.5

For the people who were members of the Group when the Group initially purchases this dental coverage, their first benefit period will begin on their Coverage Date and ends on December 31st of the following year. Therefore, their first benefit period will be longer than one year. 7.51

Deductible 7.52

Each benefit period, you must satisfy a $ deductible. This deductible applies to Primary Dental Services and Major Dental Services. In other words, after you incur eligible charges of more than $ of either Primary Dental Services or Major Dental Services in a benefit period, your benefits will begin for those services. Your other dental services are not subject to a deductible. 7.52a

Each benefit period, you must satisfy a $ deductible before your benefits begin. However, this deductible only applies to Primary Dental Services. Your other dental services are not subject to a deductible. 7.52b

If you have any expenses during the last three months of a benefit period which were or could have been applied to that benefit period's deductible, these expenses will also count as credit toward the deductible of the next benefit period. 7.53

When your Group initially purchases this dental coverage, the people who were members of the Group at that time are entitled to a special credit toward their deductible of the first benefit period. This special credit applies to expenses incurred between the date this coverage is effective and the prior January 1st. Any expenses incurred during that time which were used to satisfy a deductible under another dental benefit program can be used to satisfy the first deductible under this program. 7.54

Family Deductible

If you have Family Coverage and 3 members of your family have each satisfied their deductible, it will not be necessary for anyone else in your family to meet a deductible in that benefit period. That is, for the remainder of that benefit period, any other family members are not required to meet a deductible before receiving dental benefits. 7.55

Benefit Payment Level

When you receive any of the Covered Services described in this Dental Benefits Section, benefits will be provided at % of the Usual and Customary Fee. 7.61a

Benefit Payment Level

% of the Usual and Customary Fee will be paid for the Preventive Dental Services described in this Dental Benefits Section.

% of the Usual and Customary Fee will be paid for the Primary Dental Services described in this Dental Benefits Section. 7.61b

% of the Usual and Customary Fee will be paid for the Major Dental Services described in this Dental Benefits Section. 7.63

% of the Usual and Customary Fee will be paid for the Orthodontic Dental Services described in this Dental Benefits Section. 7.64

Benefit Payment Level

When you receive any of the Covered Services described in this Dental Benefits Section, these Covered Services will be paid according to a schedule of fixed dollar allowances (or the Usual and Customary Fee, whichever is less). The Group Policy upon which this Certificate is based contains a very detailed Indemnity Schedule. In this Certificate we have listed below the allowances for some of the more common services or procedures. Please review the Indemnity Schedule of the Group Policy if a service is not listed in this Certificate.

These allowances are not intended to affect what your Dentist charges nor to relate to the value of the service performed. However, if what you are charged is less than the scheduled allowance, the amount charged will be paid rather than the scheduled allowance.

7.61c

Schedule of Allowances **7.61c (Low Option)**

Oral Examinations	$ 5.00
Prophylaxis	$ 7.50
Topical Fluoride Application	$ 7.50
Sealants	$ 7.50
Radiographs	
— Intraoral, complete series (including bitewings—4)	$ 12.50
— Bitewing, full set	$ 10.00
— Panoramic	$ 10.00
Fillings	
— Amalgam, one surface, primary	$ 6.00
— Amalgam, one surface, permanent	$ 7.50
— Acrylic or Plastic	$ 9.00
Simple Extractions (per tooth)	$ 7.50
Endodontics	
— Pulp Cap, direct	$ 11.00
— Vital Pulpotomy	$ 17.50
— Root Canal Therapy	
one canal	$ 62.50
two canals	$ 87.50
Repair of Removable Dentures	
— Repair denture and replace one broken tooth	$ 24.00
— Replace broken clasp	$ 22.50
Recement Crowns	$ 5.00
Biopsies of Oral Tissue	$ 7.50
Oral Surgery	
— Extraction of tooth, complete bony impaction	$ 50.00
— Alevoplasty, per sextant, in conjunction with extractions	$ 20.00

— Incision and drainage of abscess	
intraoral	$ 20.00
extraoral	$ 50.00
— Treatment of Fracture, maxilla, open reduction	$250.00
— Frenulectomy	$ 37.50
— Osteoplasty	$400.00
Apicoectomy (as a separate procedure)	$ 62.50
Hemisection	$ 25.00
General Anesthesia	$ 12.50
Periodontics	
— Periodontal Prophylaxis	$ 15.00
— Cases Types Per Sextant (including all diagnostic, surgical and adjunctive services)	
Type 1—Gingivitis	$ 65.00
Type 2—Early Periodontitis	$ 75.00
Type 3—Moderate Periodontitis	$ 87.50
Type 4—Advanced Periodontitis	$100.00

Oral Examinations	$ 8.00
Prophylaxis	$ 12.00
Topical Fluoride Application	$ 12.00
Sealants	$ 10.50
Radiographs	
— Intraoral, complete series (including bitewings—4)	$ 20.00
— Bitewing, full set	$ 16.00
— Panoramic	$ 16.00
Fillings	
— Amalgam, one surface, primary	$ 9.60
— Amalgam, one surface, permanent	$ 12.00
— Acrylic or Plastic	$ 14.40
Simple Extractions (per tooth)	$ 12.00
Endodontics	
— Pulp Cap, direct	$ 17.60
— Vital Pulpotomy	$ 28.00
— Root Canal Therapy	
one canal	$108.00
two canals	$140.00
Repair of Removable Dentures	
— Repair denture and replace one broken tooth	$ 38.40
— Replace broken clasp	$ 36.00
Recement Crowns	$ 8.00
Biopsies of Oral Tissue	$ 12.00
Oral Surgery	
— Extraction of tooth, complete bony impaction	$ 80.00
— Alevoplasty, per sextant, in conjunction with	$ 32.00

extractions	
— Incision and drainage of abscess	
intraoral	$ 32.00
extraoral	$ 80.00
— Treatment of Fracture, maxilla, open reduction	$400.00
— Frenulectomy	$ 60.00
— Osteoplasty	$640.00
Apicoectomy (as a separate procedure)	$100.00
Hemisection	$ 40.00
General Anesthesia	$ 20.00
Periodontics	
— Periodontal Prophylaxis	$ 24.00
— Cases Types Per Sextant (including all diagnostic, surgical and adjunctive services)	
Type 1—Gingivitis	$104.00
Type 2—Early Periodontitis	$120.00
Type 3—Moderate Periodontitis	$140.00
Type 4—Advanced Periodontitis	$160.00

Oral Examinations	$ 7.00
Prophylaxis	$ 10.50
Topical Fluoride Application	$ 10.50
Sealants	$ 12.00
Radiographs	
— Intraoral, complete series (including bitewings—4)	$ 17.50
— Bitewing, full set	$ 14.00
— Panoramic	$ 14.00
Fillings	
— Amalgam, one surface, primary	$ 8.40
— Amalgam, one surface, permanent	$ 10.50
— Acrylic or Plastic	$ 12.60
Simple Extractions (per tooth)	$ 10.50
Endodontics	
— Pulp Cap, direct	$ 15.40
— Vital Pulpotomy	$ 24.50
— Root Canal Therapy	
one canal	$ 94.50
two canals	$122.50
Repair of Removable Dentures	
— Repair denture and replace one broken tooth	$ 33.60
— Replace broken clasp	$ 31.50
Recement Crowns	$ 7.00
Biopsies of Oral Tissue	$ 10.50
Oral Surgery	
— Extraction of tooth, complete bony impaction	$ 70.00
— Alevoplasty, per sextant, in conjunction with	$ 28.00

extractions	
— Incision and drainage of abscess	
intraoral	$ 28.00
extraoral	$ 70.00
— Treatment of Fracture, maxilla, open reduction	$350.00
— Frenulectomy	$ 52.50
— Osteoplasty	$560.00
Apicoectomy (as a separate procedure)	$ 87.50
Hemisection	$ 35.00
General Anesthesia	$ 17.50
Periodontics	
— Periodontal Prophylaxis	$ 21.00
— Cases Types Per Sextant (including all diagnostic, surgical and adjunctive services)	
Type 1—Gingivitis	$ 91.00
Type 2—Early Periodontitis	$105.00
Type 3—Moderate Periodontitis	$122.50
Type 4—Advanced Periodontitis	$140.00
Inlays, Onlays, Crowns	
— Gold Inlay, one surface	$ 50.00
— Onlay, per tooth	$ 82.50
— Crown, porcelain with metal	$100.00
— Crown, gold (full cast)	$ 80.00
Dentures	
— Complete upper	$170.00
— Complete lower	$162.50
— Partial lower (2 clasps, acrylic base, 8 teeth)	$187.50
Denture Adjustments	$ 5.00
Denture Relining	
— Complete Denture (office)	$ 37.50
— Partial Denture (office)	$ 32.50

Bridges

— Pontics	
Cast gold	$ 80.00
Porcelain fused to metal	$100.00
— Abutments	
Two surface gold inlay	$ 55.00
Gold onlay	$ 82.50
— Crowns	
Porcelain fused to metal	$100.00
Gold (full cast)	$ 80.00

Orthodontic Case Types

(includes diagnostic procedures, appliances and treatment)

— Fixed Appliances	
Permanent or Mixed Dentition	
Class 1 Malocclusion	$600.00
Class 2 or 3 Malocclusion	$700.00
— Removable Appliances	
Primary Dentition	$ 50.00

Benefit Maximum

The maximum amount available for you in dental benefits each benefit period is $. This is an individual maximum. There is no family maximum. 7.7

This maximum applies to all of your Dental Covered Services except for Orthodontic Dental Services. Orthodontic Dental Services are subject to a lifetime maximum of $. 7.71

Any expenses incurred beyond the benefit maximum are your responsibility.

IMPORTANT INFORMATION ABOUT YOUR DENTAL BENEFITS

Care By More Than One Dentist

If you should change Dentists in the middle of a particular Course of Treatment, benefits will be provided as if you had stayed with the same Dentist until your treatment was completed. There will be no duplication of benefits.

Alternate Benefit Program

In all cases in which there is more than one Course of Treatment possible, the benefit payment will be based upon the Course of Treatment bearing the lesser cost.

If you and your Dentist or Physician decide on personalized restorations or to employ specialized techniques for dental services rather than standard procedures, the benefits provided will be limited to the benefit for the standard procedures for dental services, as reasonably determined by Blue Cross and Blue Shield.

Pre-Estimation of Benefits

If your Dentist recommends a Course of Treatment that will cost more than $125, your Dentist should prepare a Claim form describing the planned treatment, copies of necessary X-rays, photographs and models and an estimate of the charges prior to your beginning the Course of Treatment. Blue Cross and Blue Shield will review the report and materials, taking into consideration alternative adequate Course of Treatment, and will notify you and your Dentist of the estimated benefits which will be provided under this Benefit Section. This is not a guarantee of payment, but an estimate of the benefits available for the proposed services to be rendered.

Special Limitations

No benefits will be provided under this Benefit Section for:

1. Dental services which are performed for cosmetic purposes.
2. Dental services or appliances for the diagnosis and/or treatment of Temporomandibular Joint Dysfunction and Related Disorders.
3. Oral Surgery for the following procedures:
   - surgical services related to a congenital malformation;
   - surgical removal of complete bony impacted teeth;
   - excision of tumors or cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth;
   - excision of exostoses of the jaws and hard palate (provided that this procedure is not done in preparation for dentures or other prostheses); treatment of fractures of facial bone; external incision and drainage of cellulitis; incision of accessory sinuses, salivary glands or ducts; reduction of dislocation, or excision of, the temporomandibular joints.
4. Dental services which are performed due to an accidental injury when caused by an external force. External force means any outside strength producing damage to the dentition and/or oral structures.
5. Hospital and ancillary charges are not covered.
6. Any services, treatments or supplies included as an eligible benefit under any other Benefit Section of this Certificate.
7. Any services, treatments or supplies included as an eligible benefit under other group hospital, medical and/or surgical coverage.

EXTENSION OF YOUR DENTAL BENEFITS IN CASE OF TERMINATION

If your coverage under this Certificate should terminate, benefits will continue for any dental Covered Services, except for periodontal treatment, described in this Benefit Section as long as the Covered Service was begun prior to the date your coverage terminated and is completed within 30 days of your termination date. No benefits will be provided for periodontal treatment after the termination of your Certificate.

DENTAL BENEFIT SECTION

Your employer has chosen Blue Cross and Blue Shield's Participating Provider Option for the administration of your dental benefits. The Participating Provider Option is a program of dental care benefits designed to provide you with economic incentives for using designated Providers of dental care services. 33.0P

As a participant in the Participating Provider Option program you will receive a directory of Participating Dentists. While there may be changes in the directory from time to time, selection of Participating Dentists by Blue Cross and Blue Shield will continue to be based upon the range of services, geographic location and cost-effectiveness of care. Notice of changes in the network will be provided to your Group Administrator annually, or as required, to allow you to make selection within the network. However, you are urged to check with your Dentist before undergoing treatment to make certain of his/her participation status. Although you can go to the Dentist of your choice, benefits under the Participating Provider Option will be greater when you use the services of a Participating Dentist. 33.0P

An important part of proper health care is maintaining good dental health. Your benefit program includes coverage for dental services and this section of your Certificate explains what dental services are covered and how much will be paid for them. 33.0T

The benefits of this section are subject to all of the terms and conditions of this Certificate. Please refer to the DEFINITIONS, ELIGIBILITY and EXCLUSIONS sections of this Certificate for additional information regarding any limitations and/or special conditions pertaining to your benefits.

For benefits to be available, dental services must be Medically Necessary and rendered and billed for by a Dentist or Physician, unless otherwise specified. No payment will be made by Blue Cross and Blue Shield until after receipt of an Attending Dentist's Statement. In addition, benefits will be provided only if services are rendered on or after your Coverage Date.

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

COVERED SERVICES

Your Dental Benefits include coverage for the following Covered Services as long as these services are rendered to you by a Dentist or a Physician. When the term "Dentist" is used in this Benefit Section, it will mean Dentist or Physician.

Preventive Dental Services

Your Preventive Dental benefits are designed to help you keep dental disease from starting or to detect it in its early stages. Your Preventive Dental Services are as follows:

- Oral Examinations—The initial oral examination and periodic routine oral examinations. However, your benefits are limited to two examinations every benefit period.
- Prophylaxis—The routine scaling and polishing of your teeth. However, your benefits are limited to two cleanings each benefit period.

- Topical Fluoride Application—Benefits for this application are only available to persons under age 19 and are limited to two applications each benefit period.
- Dental X-rays—Benefits for panoramic and routine full mouth X-rays are limited to one full mouth series (including, but not limited to, one set of bitewing X-rays) every twelve months. 33.1a
- Dental X-rays—Benefits for panoramic and routine full mouth X-rays are limited to one full mouth series (including, but not limited to, one set of bitewing X-rays) every twenty-four (24) months. 33.1b
- Dental X-rays—Benefits for panoramic and routine full mouth X-rays are limited to one full mouth series every thirty-six (36) months. Routine bitewing X-rays are limited to one set per benefit period. Any additional full mouth X-rays are subject to Medical Necessity. 33.1c
- Space Maintainers—Benefits for space maintainers are only available to persons under age 19 and not when part of orthodontic treatment. 33.2a
- Emergency oral examinations and palliative emergency treatment for the temporary relief of pain.
- Sealants—Benefits for sealants are only available to persons under age 19. 33.12a

Primary Dental Services

Your Primary Dental benefits cover a wide range of services that can help you maintain continued good dental health. These services are as follows:

- Dental X-rays—Benefits for panoramic and routine full mouth X-rays are limited to one full mouth series (including, but not limited to, one set of bitewing X-rays) every twelve months. 33.11a
- Dental X-rays—Benefits for panoramic and routine full mouth X-rays are limited to one full mouth series (including, but not limited to, one set of bitewing X-rays) every twenty-four (24) months. 33.11b
- Dental X-rays—Benefits for panoramic and routine full mouth X-rays are limited to one full mouth series every thirty-six (36) months. Routine bitewing X-rays are limited to one set per benefit period. Any additional full mouth X-rays are subject to Medical Necessity. 33.11c
- Fillings
- Extractions, except as specifically excluded under ‘‘Special Limitations’’ of this Benefit Section.
- Oral Surgery, except as specifically excluded under ‘‘Special Limitations’’ of this Benefit Section.
- Endodontics
- Pulp Vitality Tests
- Apicoectomies
- Hemisection
- Biopsies of Oral Tissue

- Periodontics/Periodontal Therapy

  Gingivectomy and gingivoplasty; gingival curettage; periodontal scaling and root planing; osseous Surgery; and mucogingival Surgery. Your benefits are limited to one full mouth treatment per benefit period.

  Periodontal maintenance procedures — Benefits for periodontal maintenance procedures are limited to two per benefit period. In addition, you must have received active periodontal therapy before benefits for these procedures will be provided.

- Stainless Steel Crowns
- Repair of Crowns, Bridges and Removable Dentures 33.13a
- Recementing of Crowns, Inlays, Onlays and Bridges 33.15a
- Space Maintainers—Benefits for space maintainers are only available to persons under age 19 and not when part of orthodontic treatment. 33.2b
- General Anesthesia/Intravenous Sedation—If Medically Necessary and administered with a covered dental procedure. The anesthesia must be given by a person who is licensed to administer general anesthesia/intravenous sedation.
- Home Visits—Visits by a Dentist to your home when medically required to render a covered dental service.
- Sealants—Benefits for sealants are only available to persons under age 19. 33.12b

Major Dental Services

Your Major Dental Benefits are designed to help you pay for certain types of more extensive dental services. These services are as follows:

- Inlays, Onlays and Crowns (other than temporary crowns and stainless steel crowns)
- Fixed Bridgework
- Repair of Crowns, Bridges and Removable Dentures 33.13b
- Recementing of Crowns, Inlays, Onlays and Bridges 33.15b
- Full and Partial Dentures
- Denture Adjustments, Rebasing and Relining—During the first six months after obtaining dentures or having them relined, adjustments are covered only if they are done by someone other than the Dentist or his in-office associates who provided or relined the dentures.
- Full Mouth Rehabilitation—Benefits will be provided for procedures necessary for eliminating oral disease and replacing missing teeth. Benefits are not available for appliances or restorations intended to increase vertical dimension.

Once you receive benefits for a crown, inlay, onlay, bridge or denture, replacements are not covered until 5 years have elapsed. Also, benefits are not available for the replacement of a bridge or denture which could have been made serviceable. 33.3

Orthodontic Dental Services

Your Dental Benefits include coverage for orthodontic appliances and treatments when they are being provided to correct problems of growth and development. These benefits are subject to the lifetime maximum and limited as follows:

- Benefits are only available for persons under age 19 and will end on their birthday. 33.41
- Benefits for orthodontic treatment will be available over the Course of Treatment.
- Benefits will not be provided for the replacement or repair of any appliance used during orthodontic treatment.

BENEFIT PAYMENT FOR DENTAL COVERED SERVICES

Benefit Period

Your Dental benefit period is a period of one year which begins on January 1st of each year. When you first enroll under this coverage, your first benefit period begins on your Coverage Date and ends on the first December 31st following that date. 33.5a

Your Dental benefit period is a period of one year which begins on of each year. When you first enroll under this coverage, your first benefit period begins on your Coverage Date but ends on the date it would normally end. 33.5b

If you were a member of the Group when the Group initially purchased this dental coverage, your first benefit period will begin on your Coverage Date and ends on December 31st of the following year. Therefore, your first benefit period will be longer than one year. 33.51

Deductible 33.52

Each benefit period, you must satisfy a $ deductible for Dental Services rendered by a Participating Dentist and a separate $ deductible for Dental Services rendered by a Non-Participating Dentist. This deductible applies to Primary Dental Services and Major Dental Services. In other words, after you incur eligible charges for more than the deductible amount for Primary Dental Services or Major Dental Services in a benefit period, your benefits will begin for those services. Your other dental services are not subject to a deductible. [$25, $50, $x] 33.52b

Each benefit period, you must satisfy a $ deductible for Dental Services rendered by a Non-Participating Dentist. This deductible applies to Primary Dental Services and Major Dental Services. In other words, after you incur eligible charges for more than $ of either Primary Dental Services or Major Dental Services in a benefit period, your benefits will begin for those services. Your other dental services are not subject to a deductible. The deductible does not apply to Dental Services rendered by a Participating Dentist. [$25, $50, $75, $x] 33.52c

Each benefit period, you must satisfy a $ deductible. This deductible applies to Primary Dental Services and Major Dental Services. In other words, after you incur eligible charges of more than $ of either Primary Dental Services or Major Dental Services in a benefit period, your benefits will begin for those services. Your other dental services are not subject to a deductible. [$25, $50, $75, $x] 33.53

Each benefit period, you must satisfy a $ deductible before your benefits begin. However, this deductible only applies to Primary Dental Services. Your other dental services are not subject to a deductible. 33.531

The deductible amount for Covered Services rendered by a Participating Dentist can be applied towards the deductible for Non-Participating Dentists and the deductible amount for Covered Services rendered by a Non-Participating Dentist can be applied towards the dedutible for Participating Dentists. 33.521a

The deductible amount for Covered Services rendered by a Non-Participating Dentist can be applied towards the deductible for Participating Dentists. 33.521b

If you have any expenses during the last three months of a benefit period which were or could have been applied to that benefit period's deductible, these expenses will also count as credit toward the deductible of the next benefit period. 33.54

When your Group initially purchased this dental coverage, if you were a member of the Group at that time you are entitled to a special credit toward your Participating Dentist deductible of the first benefit period. This special credit applies to eligible expenses incurred for Covered Services between the date this coverage is effective and the prior January 1st. Any expenses incurred during that time which were used to satisfy a deductible under another dental benefit program can be used to satisfy the Participating Dentist deductible for the first benefit period under this program. 33.55

Family Deductible

If you have Family Coverage and 3 members of your family have each satisfied their deductible, it will not be necessary for anyone else in your family to meet a deductible in that benefit period. That is, for the remainder of that benefit period, any other family members are not required to meet a deductible before receiving dental benefits. [2, 3, x] 33.56a

If you have Family Coverage and your family has reached the dental deductible amount of $, it will not be necessary for anyone else in your family to meet a deductible in that benefit period. That is, for the remainder of that benefit period, no other family member(s) is required to meet a dental deductible before receiving dental benefits. A family member may not apply more than the individual dental deductible amount toward the family dental deductible. [$50, $75, $100, $150, $225, $x] 33.56b

If you have Family Coverage and your family has reached the dental deductible amount of $ for Covered Services rendered by Participating Dentists, it will not be necessary for anyone else in your family to meet a deductible in that benefit period. That is, for the remainder of that benefit period, no other family member(s) is required to meet a dental deductible before receiving dental benefits from a Participating Dentist. A family member may not apply more than the individual dental deductible amount toward the family dental deductible. [$50, $75, $100, $150, $225, $x] 33.56c

If you have Family Coverage and your family has reached the dental deductible amount of $ for Covered Services rendered by Non-Participating Dentists, it will not be necessary for anyone else in your family to meet a deductible in that benefit period. That is, for the remainder of that benefit period, no other family member(s) is required to meet a dental deductible before receiving dental benefits from a Non-Participating Dentist. A family member may not apply more than the individual dental deductible amount toward the family dental deductible. [$50, $75, $100, $150, $225, $x] 33.56c

Benefit Payment for Dental Services

The benefits provided by Blue Cross and Blue Shield and the expenses that are your responsibility for your Covered Services will depend on whether you receive services from a Participating or Non-Participating Dentist. 33.0P

Participating Dentists are Dentists who have signed an agreement with Blue Cross and Blue Shield to accept the Maximum Allowance as payment in full. Such Participating Dentists have agreed not to bill you for Covered Service amounts in excess of the Maximum Allowance. Therefore, you will be responsible only for the difference between the Blue Cross and Blue Shield benefit payment and the Maximum Allowance for the particular Covered Service–that is, your Coinsurance amounts and deductible. 33.0P

Non-Participating Dentists are Dentists who have not signed an agreement with Blue Cross and Blue Shield to accept the Maximum Allowance as payment in full. Therefore, you are responsible to these Dentists for the difference between the Blue Cross and Blue Shield benefit payment and such Dentist's charge to you. 33.0P

Should you wish to know the Maximum Allowance for a particular procedure or whether a particular Dentist is a Participating Dentist, contact your Group Administrator, your Dentist or Blue Cross and Blue Shield. 33.0P

Participating Dentists

% of the Maximum Allowance will be paid for the Preventive Dental Services described in this Dental Benefits Section. [50% – 100%]

% of the Maximum Allowance will be paid for the Primary Dental Services described in this Dental Benefits Section. [50% – 100%]

% of the Maximum Allowance will be paid for the Major Dental Services described in this Dental Benefits Section. [50% – 100%] 33.61

% of the Maximum Allowance will be paid for the Orthodontic Dental Services described in this Dental Benefits Section. [50% – 100%] 33.63

Non-Participating Dentists

% of the Maximum Allowance Usual and Customary Fee will be paid for the Preventive Dental Services described in this Dental Benefits Section. [50% – 100%]

% of the Maximum Allowance Usual and Customary Fee will be paid for the Primary Dental Services described in this Dental Benefits Section. [50% – 100%]

% of the Maximum Allowance Usual and Customary Fee will be paid for the Major Dental Services described in this Dental Benefits Section. [50% – 100%] 33.62 33.621a 33.621b

% of the Maximum Allowance Usual and Customary Fee will be paid for the Orthodontic Dental Services described in this Dental Benefits Section. [50% – 100%] 33.63 33.631a 33.631b

Benefit Payment Level

% of the Usual and Customary Fee will be paid for the Preventive Dental Services described in this Dental Benefits Section. [50% – 100%] 33.64

% of the Usual and Customary Fee will be paid for the Primary Dental Services described in this Dental Benefits Section. [50% – 100%] 33.64

% of the Usual and Customary Fee will be paid for the Major Dental Services described in this Dental Benefits Section. [50% – 100%] 33.641

% of the Usual and Customary Fee will be paid for the Orthodontic Dental Services described in this Dental Benefits Section. [50% – 100%] 33.63 33.642

Emergency Care

Benefits for emergency oral examinations and palliative emergency treatment for the temporary relief of pain will be provided at % of the Maximum Allowance when rendered by either a Participating Dentist or Non-Participating Dentist. [50% – 100%]

Benefit Payment Level

When you receive any of the Covered Services described in this Dental Benefits Section, these Covered Services will be paid according to a schedule of fixed dollar allowances (or the Usual and Customary Fee, whichever is less). In this Certificate we have listed the allowances for some of the more common services or procedures.

These allowances are not intended to affect what your Dentist charges nor to relate to the value of the service performed. However, if what you are charged is less than the scheduled allowance, the amount charged will be paid rather than the scheduled allowance. 33.65

Benefit Maximum

The maximum amount available for you in dental benefits each benefit period is $. This is an individual maximum. There is no family maximum. [$500, $1,000, $1,500, $x] 33.7

This maximum applies to all of your Dental Covered Services except for Orthodontic Dental Services. Orthodontic Dental Services are subject to a lifetime maximum of $. [$500, $1,000, $1,500, $x] 33.71

Any expenses incurred beyond the benefit maximum are your responsibility.

IMPORTANT INFORMATION ABOUT YOUR DENTAL BENEFITS

Care By More Than One Dentist

If you should change Dentists in the middle of a particular Course of Treatment, benefits will be provided as if you had stayed with the same Dentist until your treatment was completed. There will be no duplication of benefits.

Alternate Benefit Program

In all cases in which there is more than one Course of Treatment possible, the benefit payment will be based upon the Course of Treatment bearing the lesser cost.

If you and your Dentist or Physician decide on personalized restorations or to employ specialized techniques for dental services rather than standard procedures, the benefits provided will be limited to the benefit for the standard procedures for dental services, as reasonably determined by Blue Cross and Blue Shield.

Pre-Estimation of Benefits

If your Dentist recommends a Course of Treatment that will cost more than $300, your Dentist should prepare a Claim form describing the planned treatment, copies of necessary X-rays, photographs and models and an estimate of the charges prior to your beginning the Course of Treatment. Blue Cross and Blue Shield will review the report and materials, taking into consideration alternative adequate Course of Treatment, and will notify you and your Dentist of the estimated benefits which will be provided under this Benefit Section. This is not a guarantee of payment, but an estimate of the benefits available for the proposed services to be rendered.

Special Limitations

No benefits will be provided under this Benefit Section for:

1. Dental services which are performed for cosmetic purposes.
2. Dental services or appliances for the diagnosis and/or treatment of Temporomandibular Joint Dysfunction and Related Disorders.
3. Oral Surgery for the following procedures:
   - surgical services related to a congenital malformation;
   - surgical removal of complete bony impacted teeth;
   - excision of tumors or cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth;
   - excision of exostoses of the jaws and hard palate (provided that this procedure is not done in preparation for dentures or other prostheses); treatment of fractures of facial bone; external incision and drainage of cellulitis; incision of accessory sinuses, salivary glands or ducts; reduction of dislocation, or excision of, the temporomandibular joints.
4. Dental services which are performed due to an accidental injury when caused by an external force. External force means any outside strength producing damage to the dentition and/or oral structures.
5. Hospital and ancillary charges.
6. Any services, treatments or supplies included as an eligible benefit under any other Benefit Section of this Certificate.
7. Any services, treatments or supplies included as an eligible benefit under other group hospital, medical and/or surgical coverage.
8. Implants and any related services and supplies (other than crowns) associated with the placement and care of implants.

EXTENSION OF YOUR DENTAL BENEFITS IN CASE OF TERMINATION

If your coverage under this Certificate should terminate, benefits will continue for any dental Covered Services, except for periodontal treatment and orthodontic treatment, described in this Benefit Section as long as the Covered Service was begun prior to the date your coverage terminated and is completed within 30 days of your termination date. No benefits will be provided for periodontal treatment after the ter-

mination of your Certificate. However, if orthodontic treatment is in progress at the time this Certificate terminates, benefits will continue through the end of the month in which your coverage terminates.

DENTAL BENEFIT SECTION

[Your employer has chosen Blue Cross and Blue Shield's Participating Provider Option for the administration of your dental benefits. The Participating Provider Option is a program of dental care benefits designed to provide you with economic incentives for using designated Providers of dental care services. 36.0P

As a participant in the Participating Provider Option program a directory of Participating Dentists is available to you. You can visit the Blue Cross and Blue Shield of Illinois Web site at *www.bcbsil.com* for a list of Participating Dentists. While there may be changes in the directory from time to time, selection of Participating Dentists by Blue Cross and Blue Shield will continue to be based upon the range of services, geographic location and cost-effectiveness of care. Notice of changes in the network will be provided to your Group Administrator annually, or as required, to allow you to make selection within the network. However, you are urged to check with your Dentist before undergoing treatment to make certain of his/her participation status. Although you can go to the Dentist of your choice, benefits under the Participating Provider Option will be greater when you use the services of a Participating Dentist.] 36.0P

[An important part of proper health care is maintaining good dental health. Your benefit program includes coverage for dental services and this section of your Certificate explains what dental services are covered and how much will be paid for them.] 36.0T

The benefits of this section are subject to all of the terms and conditions of this Certificate. [Certain benefits may also be subject to a Benefit Waiting Period.][If your dental benefit program has a Benefit Waiting Period, it is listed in your Benefit Highlights (an insert) of this Certificate.]Please refer to the DEFINITIONS, ELIGIBILITY and EXCLUSIONS sections of this Certificate for additional information regarding any limitations and/or special conditions pertaining to your benefits. **Revised**

For benefits to be available, dental services must be Medically Necessary and rendered and billed for by a Dentist or Physician, unless otherwise specified. No payment will be made by Blue Cross and Blue Shield until after receipt of an Attending Dentist's Statement. In addition, benefits will be provided only if services are rendered on or after your Coverage Date.

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

COVERED SERVICES

Your Dental Benefits include coverage for the following Covered Services as long as these services are rendered to you by a Dentist or a Physician. When the term "Dentist" is used in this Benefit Section, it will mean Dentist or Physician.

[Diagnostic and Preventive Dental Services 36.1

Your benefits for Diagnostic and Preventive Dental Services are designed to help you keep dental disease from starting or to detect it in its early stages. Your Diagnostic and Preventive Dental Services are as follows:

- Oral Examinations—The initial oral examination and periodic routine oral examinations. However, your benefits are limited to two examinations every benefit period.

- [Dental X-rays—Benefits for panoramic and routine full mouth X-rays are limited to one full mouth series (including, but not limited to, one set of bitewing X-rays) every twelve months.] 36.1a
- [Dental X-rays—Benefits for panoramic and routine full mouth X-rays are limited to one full mouth series (including, but not limited to, one set of bitewing X-rays) every twenty-four (24) months.] 36.1b
- [Dental X-rays—Benefits for panoramic and routine full mouth X-rays are limited to one full mouth series every thirty-six (36) months. Routine bitewing X-rays are limited to one set per benefit period. Additional full mouth X-rays are covered only if Medically Necessary.] 36.1c
- Prophylaxis—The routine scaling and polishing of your teeth. However, your benefits are limited to two cleanings each benefit period.[If you are pregnant, benefits will be provided for one additional prophylaxis treatment.] **New** 36.0; 36.1h
- Topical Fluoride Application[—Benefits for this application[are only available to persons under age [5–30] and] are limited to two applications each benefit period.] 36.1d
- [Sealants[—Benefits for sealants are only available to persons under age [5–30].]] 36.1e 36.1e1
- [Space Maintainers—Benefits for space maintainers are only available [to persons under age [5–30]]when not part of orthodontic treatment.] 36.1f 36.1f1
- [Emergency oral examinations and palliative emergency treatment for the temporary relief of pain.]] 36.1g

[**Miscellaneous Dental Services** 36.2

- [Dental X-rays—Benefits for panoramic and routine full mouth X-rays are limited to one full mouth series (including, but not limited to, one set of bitewing X-rays) every twelve months.] 36.2a
- [Dental X-rays—Benefits for panoramic and routine full mouth X-rays are limited to one full mouth series (including, but not limited to, one set of bitewing X-rays) every twenty-four (24) months.] 36.2b
- [Dental X-rays—Benefits for panoramic and routine full mouth X-rays are limited to one full mouth series every thirty-six (36) months. Routine bitewing X-rays are limited to one set per benefit period. Additional full mouth X-rays are covered only if Medically Necessary.] 36.2c
- [Sealants[—Benefits for sealants are only available to persons under age [5–30].] 36.2e 36.2e1
- [Space Maintainers—Benefits for space maintainers are only available [to persons under age [5–30]]when not part of orthodontic treatment.] 36.2f 36.2f1
- Labs and Tests—Pulp vitality tests.
- [Emergency oral examinations and palliative emergency treatment for the temporary relief of pain.]] 36.2g

[Restorative Dental Services 36.3

- Amalgams (Fillings)
- Pin Retention
- Composites
- Simple Extractions, except as specifically excluded under ‘‘Special Limitations’’ of this Benefit Section.]

[General Dental Services 36.4

- General Anesthesia/Intravenous Sedation—If Medically Necessary and administered with a covered dental procedure. The anesthesia must be given by a person who is licensed to administer general anesthesia/intravenous sedation.
- Home Visits—Visits by a Dentist to your home when medically required to render a covered dental service.
- Injection of antibiotic drugs 36.41
- Stainless Steel Crowns]

[Endodontic Services 36.5

- Root canal therapy
- Pulp cap
- Apicoectomy
- Apexification
- Retrograde filling
- Root amputation/hemisection
- Therapeutic pulpotomy
- Pulpal debridement]

[Periodontic Services 36.6

- Periodontal scaling and root planing
- Full mouth debridement
- Gingivectomy/gingivoplasty—Your benefits are limited to one full mouth treatment per benefit period.
- Gingival flap procedure
- Osseous Surgery—Your benefits are limited to one full mouth treatment per benefit period.
- Osseous grafts
- Soft tissue grafts
- Periodontal maintenance procedures—Benefits for periodontal maintenance procedures are limited to two per benefit period. In addition, you must have re-

ceived active periodontal therapy before benefits for these procedures will be provided. [If you are pregnant, benefits are available for one additional periodontal maintenance procedure.]

New
36.6; 36.6h

[**Oral Surgery Services** 36.7

- Surgical tooth extraction
- Alveoloplasty
- Vestibuloplasty
- Other necessary dental surgical procedures]

[**Crowns, Inlays/Onlays Services** 36.8

- Prefabricated post and cores
- Cast post and cores
- Crowns, inlays/onlays repairs
- Recementation of crowns, inlays/onlays]

[**Prosthodontic Services** 36.9

- Bridges
- Dentures
- Adjustments to Bridges and Dentures—During the first six months after obtaining dentures or having them relined, adjustments are covered only if they are done by someone other than the Dentist or his in-office associates who provided or relined the dentures.
- Bridge and Denture repairs
- Addition of tooth or clasp
- Reline/Rebase

Once you receive benefits for a crown, inlay, onlay, bridge or denture, replacements are not covered until 5 years have elapsed. Also, benefits are not available for the replacement of a bridge or denture which could have been made serviceable.]

[**Implants**] 36.10

[**Orthodontic Dental Services** 36.11

Your Dental Benefits include coverage for orthodontic appliances and treatments when they are being provided to correct problems of growth and development. These benefits are subject to the lifetime maximum and limited as follows:

- [Benefits are only available for persons under age [5–30] and will end on their birthday.] 36.111
- Benefits for orthodontic treatment will be available over the Course of Treatment.

- Benefits will not be provided for the replacement or repair of any appliance used during orthodontic treatment.]

[**Temporomandibular Joint (TMJ) Services**] 36.12

BENEFIT PAYMENT FOR DENTAL COVERED SERVICES

Benefit Period

[Your Dental benefit period is a period of one year which begins on January 1st of each year. When you first enroll under this coverage, your first benefit period begins on your Coverage Date and ends on the first December 31st following that date.] 36.5a

[Your Dental benefit period is a period of one year which begins on [Month Day] of each year. When you first enroll under this coverage, your first benefit period begins on your Coverage Date but ends on the date it would normally end.] 36.5b

[If you were a member of the Group when the Group initially purchased this dental coverage, your first benefit period will begin on your Coverage Date and ends on December 31st of the following year. Therefore, your first benefit period will be longer than one year.] 36.51

[**Deductible** 36.52

[[Each benefit period, you must satisfy a $[5–500] deductible for Dental Services rendered by a Participating Dentist and a separate $[5–500] deductible for Dental Services rendered by a Non-Participating Dentist. This deductible applies to:] 36.52bD

[Each benefit period, you must satisfy the deductible amounts specified in the Benefit Highlights (an insert) of this Certificate. Separate deductibles apply for dental services rendered by Participating Dentists and dental services rendered by Non-Participating Dentists. These deductibles apply to:] 36.52bG

- [Diagnostic and Preventive Dental Services] 36.52b1
- [Miscellaneous Dental Services] 36.52b2
- [Restorative Dental Services] 36.52b3
- [General Dental Services] 36.52b4
- [Endodontic Services] 36.52b5
- [Periodontic Services] 36.52b6
- [Oral Surgery Services] 36.52b7
- [Crowns, Inlays/Onlays Services] 36.52b8
- [Prosthodontic Services] 36.52b9
- [Implants] 36.52b11
- [Orthodontic Dental Services] 36.52b10
- [Temporomandibular Joint Services] 36.52b12

In other words, after you incur eligible charges for more than the deductible amount for the Covered Services listed above in a benefit period, your benefits will begin for those services.[Your other dental services are not subject to a deductible.]] 36.52b

[[Each benefit period, you must satisfy a $[5–500] deductible for Dental Services rendered by a Non-Participating Dentist. This deductible applies to:] 36.52cD

[Each benefit period, you must satisfy the deductible amount specified in the Benefit Highlights (an insert) of this Certificate for dental services rendered by a Non-Participating Dentist. This deductible applies to:] 36.52cG

- [Diagnostic and Preventive Dental Services] 36.52c1
- [Miscellaneous Dental Services] 36.52c2
- [Restorative Dental Services] 36.52c3
- [General Dental Services] 36.52c4
- [Endodontic Services] 36.52c5
- [Periodontic Services] 36.52c6
- [Oral Surgery Services] 36.52c7
- [Crowns, Inlays/Onlays Services] 36.52c8
- [Prosthodontic Services] 36.52c9
- [Implants] 36.52c11
- [Orthodontic Dental Services] 36.52c10
- [Temporomandibular Joint Services] 36.52c12

In other words, after you incur eligible charges for more than the deductible amount for the Covered Services listed above in a benefit period, your benefits will begin for those services.[Your other dental services are not subject to a deductible.] The deductible does not apply to Dental Services rendered by a Participating Dentist.] 36.52c

[[Each benefit period, you must satisfy a $[5–500] deductible. This deductible applies to:] 36.53D

[Each benefit period, you must satisfy the deductible amount specified in the Benefit Highlights (an insert) of this Certificate. This deductible applies to:] 36.53G

- [Diagnostic and Preventive Dental Services] 36.531
- [Miscellaneous Dental Services] 36.532
- [Restorative Dental Services] 36.533
- [General Dental Services] 36.534
- [Endodontic Services] 36.535
- [Periodontic Services] 36.536
- [Oral Surgery Services] 36.537
- [Crowns, Inlays/Onlays Services] 36.538
- [Prosthodontic Services] 36.539

- [Implants] 36.5311
- [Orthodontic Dental Services] 36.5310
- [Temporomandibular Joint Services] 36.5312

In other words, after you incur eligible charges of more than the deductible amount for the Covered Services listed above in a benefit period, your benefits will begin for those services.[Your other dental services are not subject to a deductible.]] 36.53

[The deductible amount for Covered Services rendered by a Participating Dentist can be applied towards the deductible for Non-Participating Dentists and the deductible amount for Covered Services rendered by a Non-Participating Dentist can be applied towards the deductible for Participating Dentists.] 36.521a

[The deductible amount for Covered Services rendered by a Non-Participating Dentist can be applied towards the deductible for Participating Dentists.] 36.521b

[If you have any expenses during the last three months of a benefit period which were or could have been applied to that benefit period's deductible, these expenses will also count as credit toward the deductible of the next benefit period.] 36.54

[When your Group initially purchased this dental coverage, if you were a member of the Group at that time you are entitled to a special credit toward your Participating Dentist deductible of the first benefit period. This special credit applies to eligible expenses incurred for Covered Services between the date this coverage is effective and the prior January 1st. Any expenses incurred during that time which were used to satisfy a deductible under another dental benefit program can be used to satisfy the Participating Dentist deductible for the first benefit period under this program.]] 36.55

[**Family Deductible**

[If you have Family Coverage and [2,3] members of your family have each satisfied their deductible, it will not be necessary for anyone else in your family to meet a deductible in that benefit period. That is, for the remainder of that benefit period, any other family members are not required to meet a deductible before receiving dental benefits.] 36.56a

[If you have Family Coverage and your family has reached the dental deductible amount of $[5–500], it will not be necessary for anyone else in your family to meet a deductible in that benefit period. That is, for the remainder of that benefit period, no other family member(s) is required to meet a dental deductible before receiving dental benefits. A family member may not apply more than the individual dental deductible amount toward the family dental deductible.] 36.56bD

[If you have Family Coverage and your family has reached the family dental deductible amount specified in the Benefit Highlights (an insert) of this Certificate, it will not be necessary for anyone else in your family to meet a deductible in that benefit period. That is, for the remainder of that benefit period, no other family member(s) is required to meet a dental deductible before receiving dental benefits. A family member may not apply more than the individual dental deductible amount toward the family dental deductible.] 36.56bG

[If you have Family Coverage and your family has reached the dental deductible amount of $[5–500] for Covered Services rendered by Participating Dentists, it will

not be necessary for anyone else in your family to meet a deductible in that benefit period. That is, for the remainder of that benefit period, no other family member(s) is required to meet a dental deductible before receiving dental benefits from a Participating Dentist. A family member may not apply more than the individual dental deductible amount toward the family dental deductible.] 36.56cD

[If you have Family Coverage and your family has reached the family dental deductible amount specified in the Benefit Highlights (an insert) of this Certificate for Covered Services rendered by Participating Dentists, it will not be necessary for anyone else in your family to meet a deductible in that benefit period. That is, for the remainder of that benefit period, no other family member(s) is required to meet a dental deductible before receiving dental benefits from a Participating Dentist. A family member may not apply more than the individual dental deductible amount toward the family dental deductible.]

[If you have Family Coverage and your family has reached the dental deductible amount of $[5–500] for Covered Services rendered by Non-Participating Dentists, it will not be necessary for anyone else in your family to meet a deductible in that benefit period. That is, for the remainder of that benefit period, no other family member(s) is required to meet a dental deductible before receiving dental benefits from a Non-Participating Dentist. A family member may not apply more than the individual dental deductible amount toward the family dental deductible.]] 36.56c2D

[If you have Family Coverage and your family has reached the family dental deductible amount specified in the Benefit Highlights (an insert) of this Certificate for Covered Services rendered by Non-Participating Dentists, it will not be necessary for anyone else in your family to meet a deductible in that benefit period. That is, for the remainder of that benefit period, no other family member(s) is required to meet a dental deductible before receiving dental benefits from a Non-Participating Dentist. A family member may not apply more than the individual dental deductible amount toward the family dental deductible.] 36.56c2G

[**Benefit Payment for Dental Services**

The benefits provided by Blue Cross and Blue Shield and the expenses that are your responsibility for your Covered Services will depend on whether you receive services from a Participating or Non-Participating Dentist. 36.0P

[Benefits for Covered Services will be provided at the payment levels specified in the Benefit Highlights (an insert) of this Certificate.] 36.61G

Participating Dentists are Dentists who have signed an agreement with Blue Cross and Blue Shield to accept the Maximum Allowance as payment in full. Such Participating Dentists have agreed not to bill you for Covered Service amounts in excess of the Maximum Allowance. Therefore, you will be responsible only for the difference between the Blue Cross and Blue Shield benefit payment and the Maximum Allowance for the particular Covered Service–that is, your Coinsurance amounts and deductible. 36.0P

Non-Participating Dentists are Dentists who have not signed an agreement with Blue Cross and Blue Shield to accept the Maximum Allowance as payment in full. Therefore, you are responsible to these Dentists for the difference between the Blue Cross and Blue Shield benefit payment and such Dentist's charge to you. 36.0P

Should you wish to know the Maximum Allowance for a particular procedure or whether a particular Dentist is a Participating Dentist, contact your Group Administrator, your Dentist or Blue Cross and Blue Shield.] 36.0P

[**Participating Dentists**

[**Diagnostic and Preventive Dental Services –** Benefits for Diagnostic and Preventive Dental Services described in this Dental Benefits Section received from a Participating Dentist will be provided at [50–100]% of the Maximum Allowance[after you have met your deductible].] 36.61a

[If you are pregnant, benefits will be provided for one additional prophylaxis treatment at 100% of the Maximum Allowance.] **New** 36.61m

[**Miscellaneous Dental Services –** Benefits for Miscellaneous Dental Services described in this Dental Benefits Section received from a Participating Dentist will be provided at [50–100]% of the Maximum Allowance[after you have met your deductible].] 36.61b

[**Restorative Dental Services –** Benefits for Restorative Dental Services described in this Dental Benefits Section received from a Participating Dentist will be provided at [50–100]% of the Maximum Allowance[after you have met your deductible].] 36.61c

[**General Dental Services –** Benefits for General Dental Services described in this Dental Benefits Section received from a Participating Dentist will be provided at [50–100]% of the Maximum Allowance[after you have met your deductible].] 36.61d

[**Endodontic Services –** Benefits for Endodontic Services described in this Dental Benefits Section received from a Participating Dentist will be provided at [50–100]% of the Maximum Allowance[after you have met your deductible].] 36.61e

[**Periodontic Services –** Benefits for Periodontic Services described in this Dental Benefits Section received from a Participating Dentist will be provided at [50–100]% of the Maximum Allowance[after you have met your deductible]. 36.61f

[If you are pregnant benefits will be provided for one additional periodontal maintenance procedure at 100% of the Maximum Allowance.] **New** 36.61n

[If you are pregnant or diagnosed with diabetes or heart disease, benefits for periodontal scaling, root planing and periodontal maintenance procedures will be provided at 100% of the Maximum Allowance.] **New** 36.61o

[**Oral Surgery Services –** Benefits for Oral Surgery Services described in this Dental Benefits Section received from a Participating Dentist will be provided at [50–100]% of the Maximum Allowance[after you have met your deductible].] 36.61g

[**Crowns, Inlays/Onlays Services –** Benefits for Crowns, Inlays/Onlays Services described in this Dental Benefits Section received from a Participating Dentist will be provided at [50–100]% of the Maximum Allowance[after you have met your deductible].] 36.61h

[**Prosthodontic Services –** Benefits for Prosthodontic Services described in this Dental Benefits Section received from a Participating Dentist will be provided at [50–100]% of the Maximum Allowance[after you have met your deductible].] 36.61i

[**Implants** – Benefits for Implants described in this Dental Benefits Section received from a Participating Dentist will be provided at [50–100]% of the Maximum Allowance[after you have met your deductible]. 36.61k

[**Orthodontic Dental Services** – Benefits for Orthodontic Dental Services described in this Dental Benefits Section received from a Participating Dentist will be provided at [50–100]% of the Maximum Allowance[after you have met your deductible].] 36.61j

[**Temporomandibular Joint Services** – Benefits for Temporomandibular Joint Services described in this Dental Benefits Section received from a Participating Dentist will be provided at [50–100]% of the Maximum Allowance[after you have met your deductible].] 36.61l

[**Non-Participating Dentists**

[**Diagnostic and Preventive Dental Services** – Benefits for Diagnostic and Preventive Dental Services described in this Dental Benefits Section received from a Non-Participating Dentist will be provided at [50–100]% of the [Maximum Allowance][Usual and Customary Fee][after you have met your deductible]]. 36.62a

[If you are pregnant, benefits will be provided for one additional prophylaxis treatment at 100% of the Maximum Allowance.] **New** 36.62m

[**Miscellaneous Dental Services** – Benefits for Miscellaneous Dental Services described in this Dental Benefits Section received from a Non-Participating Dentist will be provided at [50–100]% of the [Maximum Allowance][Usual and Customary Fee] [after you have met your deductible]]. 36.62b

[**Restorative Dental Services** – Benefits for Restorative Dental Services described in this Dental Benefits Section received from a Non-Participating Dentist will be provided at [50–100]% of the [Maximum Allowance][Usual and Customary Fee][after you have met your deductible]]. 36.62c

[**General Dental Services** – Benefits for General Dental Services described in this Dental Benefits Section received from a Non-Participating Dentist will be provided at [50–100]% of the [Maximum Allowance][Usual and Customary Fee][after you have met your deductible].] 36.62d

[**Endodontic Services** – Benefits for Endodontic Services described in this Dental Benefits Section received from a Non-Participating Dentist will be provided at [50–100]% of the [Maximum Allowance][Usual and Customary Fee][after you have met your deductible].] 36.62e

[**Periodontic Services** – Benefits for Periodontic Services described in this Dental Benefits Section received from a Non-Participating Dentist will be provided at [50–100]% of the [Maximum Allowance][Usual and Customary Fee][after you have met your deductible]. 36.62f

[If you are pregnant benefits will be provided for one additional periodontal maintenance procedure at 100% of the Maximum Allowance.] **New** 36.62n

[If you are pregnant or diagnosed with diabetes or heart disease, benefits for periodontal scaling, root planing and periodontal maintenance procedures will be provided at 100% of the Maximum Allowance.] **New** 36.62o

[**Oral Surgery Services –** Benefits for Oral Surgery Services described in this Dental Benefits Section received from a Non-Participating Dentist will be provided at [50–100]% of the [Maximum Allowance][Usual and Customary Fee][after you have met your deductible].] 36.62g

[**Crowns, Inlays/Onlays Services –** Benefits for Oral Surgery Services described in this Dental Benefits Section received from a Non-Participating Dentist will be provided at [50–100]% of the [Maximum Allowance][Usual and Customary Fee][after you have met your deductible].] 36.62h

[**Prosthodontic Services –** Benefits for Prosthodontic Services described in this Dental Benefits Section received from a Non-Participating Dentist will be provided at [50–100]% of the [Maximum Allowance][Usual and Customary Fee][after you have met your deductible].] 36.62i

[**Implants –** Benefits for Implants described in this Dental Benefits Section received from a Non-Participating Dentist will be provided at [50–100]% of the [Maximum Allowance][Usual and Customary Fee][after you have met your deductible].] 36.62k

[**Orthodontic Dental Services –** Benefits for Orthodontic Dental Services described in this Dental Benefits Section received from a Non-Participating Dentist will be provided at [50–100]% of the [Maximum Allowance][Usual and Customary Fee][after you have met your deductible].] 36.62j

[**Temporomandibular Joint Services –** Benefits for Temporomandibular Joint Services described in this Dental Benefits Section received from a Non-Participating Dentist will be provided at [50–100]% of the [Maximum Allowance][Usual and Customary Fee][after you have met your deductible].] 36.62l

[**Benefit Payment Level**

[Benefits for Covered Services will be provided at the payment levels specified in the Benefit Highlights (an insert) of this Certificate.] 36.64G

[**Diagnostic and Preventive Dental Services –** Benefits for Diagnostic and Preventive Dental Services described in this Dental Benefits Section will be provided at [50–100]% of the Usual and Customary Fee[after you have met your deductible].] 36.64a

[If you are pregnant, benefits will be provided for one additional prophylaxis treatment at 100% of the Usual and Customary Fee.] **New** 36.64m

[**Miscellaneous Dental Services –** Benefits for Miscellaneous Dental Services described in this Dental Benefits Section will be provided at [50–100]% of the Usual and Customary Fee[after you have met your deductible].] 36.64b

[**Restorative Dental Services –** Benefits for Restorative Dental Services described in this Dental Benefits Section will be provided at [50–100]% of the Usual and Customary Fee[after you have met your deductible].] 36.64c

[**General Dental Services –** Benefits for General Dental Services described in this Dental Benefits Section will be provided at [50–100]% of the Usual and Customary Fee[after you have met your deductible].] 36.64d

[**Endodontic Services –** Benefits for Endodontic Services described in this Dental Benefits Section will be provided at [50–100]% of the Usual and Customary Fee[after you have met your deductible].] 36.64e

[**Periodontic Services** – Benefits for Periodontic Services described in this Dental Benefits Section will be provided at [50–100]% of the Usual and Customary Fee[after you have met your deductible].] 36.64f

[**Oral Surgery Services** – Benefits for Oral Surgery Services described in this Dental Benefits Section will be provided at [50–100]% of the Usual and Customary Fee[after you have met your deductible].] 36.64g

[**Crowns, Inlays/Onlays Services** – Benefits for Crowns, Inlays/Onlays Services described in this Dental Benefits Section will be provided at [50–100]% of the Usual and Customary Fee[after you have met your deductible].] 36.64h

[**Prosthodontic Services** – Benefits for Prosthodontic Services described in this Dental Benefits Section will be provided at [50–100]% of the Usual and Customary Fee[after you have met your deductible].] 36.64i

[**Implants** – Benefits for Implants described in this Dental Benefits Section will be provided at [50–100]% of the Usual and Customary Fee[after you have met your deductible].] 36.64k

[**Orthodontic Dental Services** – Benefits for Orthodontic Dental Services described in this Dental Benefits Section will be provided at [50–100]% of the Usual and Customary Fee[after you have met your deductible].] 36.64j

[**Temporomandibular Joint Services** – Benefits for Temporomandibular Joint Services described in this Dental Benefits Section will be provided at [50–100]% of the Usual and Customary Fee[after you have met your deductible].] 36.64l

[**Emergency Care** 36.61ec

[Benefits for emergency oral examinations and palliative emergency treatment for the temporary relief of pain will be provided at [50–100]% of the Maximum Allowance when rendered by either a Participating Dentist or Non-Participating Dentist.] 36.612

[Benefits for emergency oral examinations and palliative emergency treatment for the temporary relief of pain will be provided at [50–100]% of the Maximum Allowance when rendered by a Participating Dentist or at [50–100]% of the Usual and Customary Fee when rendered by a Non-Participating Dentist.] 36.611

[Benefits for emergency oral examinations and palliative emergency treatment for the temporary relief of pain will be provided at the [Diagnostic and Preventive Dental Services][Miscellaneous Dental Services] payment level specified in the Benefit Highlights (an insert) of this Certificate for Participating Dentists when rendered by either a Participating Dentist or Non-Participating Dentist.]] 36.61G

[**Benefit Maximum** 36.70

[The maximum amount available for you in dental benefits each benefit period is $[500–60,000]. This is an individual maximum. There is no family maximum.] 36.71

[The maximum amount available for you in dental benefits each benefit period (your Benefit Period Maximum) is specified in the Benefit Highlights (an insert) of this Certificate. This is an individual maximum. There is no family maximum.] 36.70G

[The maximum amount available for you in dental benefits each benefit period is $[500–60,000] for Covered Services rendered by a Participating Dentist or

$[500–60,000] for Covered Services rendered by a Non-Participating Dentist. These are individual maximums. There is no family maximum.] 36.72

[This maximum applies to all of your Dental Covered Services except for Orthodontic Dental Services. Orthodontic Dental Services are subject to a lifetime maximum of $[500–60,000].] 36.73D

[This maximum applies to all of your dental Covered Services except for Orthodontic Dental Services. Orthodontic Dental Services are subject to the Orthodontic Services Lifetime Maximum specified in the Benefit Highlights (an insert) of this Certificate.] 36.73G

Any expenses incurred beyond the benefit maximum are your responsibility.]

[Graduated Benefit Period Maximum **New** 36.81

[If indicated in the Benefit Highlights (an insert) of this Certificate, your dental program provides automatic increases to your Benefit Period Maximum in the amount of the Graduated Benefit Period Maximum Increment shown. These incremental increases will apply separately to each individual and become effective on the first day of the new benefit period following your anniversary. The highest benefit period maximum level is capped after [one–10]incremental increases. 36.81G; 36.81Ga

[Your dental program provides automatic increases to your benefit period maximum in the amount of $[5–500]. These incremental increases will apply separately to each individual and become effective on the first day of the new benefit period following your anniversary. The highest benefit period maximum level is capped after [one–10] incremental increases.]] 36.81D, 36.82, 36.82a

IMPORTANT INFORMATION ABOUT YOUR DENTAL BENEFITS

Care By More Than One Dentist

If you should change Dentists in the middle of a particular Course of Treatment, benefits will be provided as if you had stayed with the same Dentist until your treatment was completed. There will be no duplication of benefits.

Alternate Benefit Program

In all cases in which there is more than one Course of Treatment possible, the benefit payment will be based upon the Course of Treatment bearing the lesser cost.

If you and your Dentist or Physician decide on personalized restorations or to employ specialized techniques for dental services rather than standard procedures, the benefits provided will be limited to the benefit for the standard procedures for dental services, as reasonably determined by Blue Cross and Blue Shield.

Pre-Estimation of Benefits

If your Dentist recommends a Course of Treatment that will cost more than $[100–5,000], your Dentist should prepare a Claim form describing the planned treatment, copies of necessary X-rays, photographs and models and an estimate of the charges prior to your beginning the Course of Treatment. Blue Cross and Blue Shield will review the report and materials, taking into consideration alternative adequate Course of Treatment, and will notify you and your Dentist of the estimated benefits 36.80

which will be provided under this Benefit Section. This is not a guarantee of payment, but an estimate of the benefits available for the proposed services to be rendered.

Special Limitations

No benefits will be provided under this Benefit Section for:

1. Dental services which are performed for cosmetic purposes.
2. Dental services or appliances for the diagnosis and/or treatment of Temporomandibular Joint Dysfunction and Related Disorders, unless specifically mentioned in this benefit section.
3. Oral Surgery for the following procedures:
   - surgical services related to a congenital malformation;
   - [surgical removal of complete bony impacted teeth;]
   - excision of tumors or cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth;
   - excision of exostoses of the jaws and hard palate (provided that this procedure is not done in preparation for dentures or other prostheses); treatment of fractures of facial bone; external incision and drainage of cellulitis; incision of accessory sinuses, salivary glands or ducts; reduction of dislocation, or excision of, the temporomandibular joints.
4. Dental services which are performed due to an accidental injury when caused by an external force. External force means any outside strength producing damage to the dentition and/or oral structures.
5. Hospital and ancillary charges.
6. Any services, treatments or supplies included as an eligible benefit under any other Benefit Section of this Certificate.
7. Any services, treatments or supplies included as an eligible benefit under other group hospital, medical and/or surgical coverage.
8. [Implants and any related services and supplies (other than crowns) associated with the placement and care of implants, unless specifically mentioned in this benefit section.]

EXTENSION OF YOUR DENTAL BENEFITS IN CASE OF TERMINATION

If your coverage under this Certificate should terminate, benefits will continue for any dental Covered Services, except for periodontal treatment[and orthodontic treatment,] described in this Benefit Section as long as the Covered Service was begun prior to the date your coverage terminated and is completed within 30 days of your termination date. No benefits will be provided for periodontal treatment after the termination of your Certificate.[However, if orthodontic treatment is in progress at the time this Certificate terminates, benefits will continue through the end of the month in which your coverage terminates.]

DENTAL BENEFIT SECTION

An important part of proper health care is maintaining good dental health. Your benefit program includes coverage for dental services and this section of your Certificate explains what dental services are covered and how much will be paid for them.

The benefits of this section are subject to all of the terms and conditions of this Certificate. Please refer to the DEFINITIONS, ELIGIBILITY and EXCLUSIONS sections of this Certificate for additional information regarding any limitations and/or special conditions pertaining to your benefits.

For benefits to be available, dental services must be Medically Necessary and rendered and billed for by a Dentist or Physician, unless otherwise specified. No payment will be made by Blue Cross and Blue Shield until after receipt of a Dentist's or Physician's Claim form. In addition, benefits will be provided only if services are rendered on or after your Coverage Date.

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

COVERED SERVICES

Your Dental Benefits include coverage for the following Covered Services as long as these services are rendered to you by a Dentist or a Physician. When the term "Dentist" is used in this Benefit Section, it will mean Dentist or Physician.

Basic Dental Services

Your Basic Dental Services benefits are designed to help you keep dental disease from starting or to detect it in early stages and can help you maintain continued good dental health. Your Basic Dental Services are as follows:

- Oral Examinations—That is, an initial oral examination and periodic routine oral examinations. However, your benefits are limited to two examinations every benefit period.
- Prophylaxis—That is, cleaning, scaling and polishing of your teeth. However, your benefits are limited to two cleanings each benefit period.
- Topical Fluoride Application—Benefits for this application are only available to persons under age 19 and are limited to one application every six months.
- Dental X-rays—Benefits for routine X-rays are limited to one full mouth X-ray and an additional bitewing X-ray every twelve months.
- Fillings—Benefits for fillings are limited to those consisting of silver amalgam, silicate, and plastic.
- Simple Extractions—That is, routine extractions not requiring surgical incision or excision.
- Repair of removal dentures
- Recementing of Crowns, Inlays and Bridges
- Endodontics

- Pulp Vitality Tests—Benefits for these tests are limited to once every twelve months.
- Biopsies of Oral Tissues
- Emergency Treatment—That is, emergency oral examinations and treatment for the relief of pain.
- Home Visits—That is, visits by a Dentist to your home when medically required to render a covered dental service. 11.1

Additional Basic Dental Services

Your Additional Basic Dental benefits are designed to help you pay for certain types of more extensive dental services. These services are as follows:

- Oral Surgery
- Space Maintainers—Benefits for space maintainers are only available to persons under age 19 and not when part of orthodontic treatment.
- Inlays, Onlays and Crowns—That is, when the inlay, onlay or crown is not a part of a bridge.
- Apicoectomies
- Hemisection 11.2

Prosthodontic Dental Services

Your Prosthodontic Dental benefits are designed to help you pay for artificial teeth to prevent other teeth from shifting into a gap. These services are as follows:

- Bridges
- Full and Partial Dentures
- Denture Adjustments and Relining—That is, during the first six months after obtaining dentures or having them repaired, adjustments are covered only if they are done by someone other than the Dentist or his in-office associates who provided or repaired the dentures.

Once you receive benefits for a bridge or denture, replacements are not covered until 5 years have elapsed. Also, benefits are not available for the replacement of a bridge or denture which could have been made serviceable. 11.3

Periodontic Dental Services

Your Periodontic Dental benefits are designed to help you pay for gum disease treatment.

These services are as follows:

- Surgical periodontic examination
- Gingival Curettage—That is, the scraping of tissue around the teeth.
- Osseous Surgery, including flap entry and closure

- Gingivectomy and Gingivoplasty—That is, the surgical removal of diseased gingival tissue and reshaping of the tissue around teeth.
- Mucogingivoplastic Surgery—That is, the repositioning of soft tissue.
- Management of Acute Periodontal Infection and Oral Lesions 11.4

Orthodontic Dental Services

Your Dental Benefits include coverage for orthodontic appliances and treatments when they are being provided to correct problems of growth and development (which may be the cause of malocclusion). These benefits are limited as follows:

- Benefits are only available for persons under age 19 and will end at the end of the month in which that age is reached.
- Diagnostic benefits, including examination, study models,
- X-rays and all other diagnostic aids, will be provided only once in any 5 year period, beginning with the date of the first visit to the Dentist.
- Benefits for active orthodontic treatment are limited to 36 consecutive months of treatment and benefits for retention treatment are limited to 18 consecutive months. If you are receiving treatment when your coverage begins, these time periods will be reduced by the number of months that you have been receiving treatment prior to your coverage beginning.
- Benefits will not be provided for the replacement or repair of any appliance used during orthodontic treatment.
- After your orthodontic treatment has been completed, no further benefits will be provided until 5 years have elapsed. 11.5

PAYMENT FOR DENTAL COVERED SERVICES

Benefit Period

Your Dental benefit period is a period of one year which begins on January 1st of each year. When you first enroll under this coverage, your first benefit period begins on your Coverage Date but ends on the date it would normally end. 11.6

Deductible

Each benefit period, you must satisfy a $ deductible. This deductible applies to any of the Covered Services described in this Dental Benefit Section. In other words, after you incur charges of more than $, for Covered Services, your benefits will begin for those services. 11.61a

Deductible

Each benefit period, you must satisfy a $ deductible. This deductible applies to any of the Covered Services described in this Dental Benefits Section, except Orthodontic Dental Services. In other words, after you incur charges of more than $, your benefits will begin for those services. Orthodontic Dental Service benefits begin when you incur eligible Orthodontic Dental Services. 11.61b

Family Deductible

If you have Family Coverage and 3 members of your family have each satisfied their deductible, it will not be necessary for anyone else in your family to meet a deductible in that benefit period. That is, for the remainder of that benefit period, any other family members are not required to meet a deductible before receiving dental benefits. 11.62

Benefit Payment Level

% of the Usual and Customary Fee will be paid for . 50% of the Usual and Customary Fee will be paid for Orthodontic Dental benefits. 11.631

Benefit Payment Level

When you receive any of the Covered Services described in this Dental Benefits Section, these Covered Services will be paid according to a schedule of fixed dollar allowances (or the Usual and Customary Fee, whichever is less). The Group Policy upon which this Certificate is based contains a very detailed Indemnity Schedule. In this Certificate we have listed below the allowances for some of the more common services or procedures. Please review the Indemnity Schedule of the Group Policy if a service is not listed in this Certificate.

These allowances are not intended to affect what your Dentist charges nor to relate to the value of the service performed. However, if what you are charged is less than the scheduled allowance, the amount charged will be paid rather than the scheduled allowance. 11.632

Oral Examinations	$ 3.50
Prophylaxis	$ 7.00
Topical Fluoride Application	$ 9.00
Sealants	$ 9.00
Radiographs	
— Intraoral, complete series (including bitewings—4)	$ 12.00
— Bitewing, full set	$ 3.00
— Panoramic	$ 14.00
Fillings	
— Amalgam, one surface, primary	$ 5.00
— Amalgam, one surface, permanent	$ 5.50
— Acrylic or Plastic	$ 10.00
Simple Extractions (per tooth)	$ 7.00
Endodontics	
— Pulp Cap, direct	$ 7.00
— Vital Pulpotomy	$ 17.50
— Root Canal Therapy	
one canal	$ 63.00
two canals	$ 94.50
Repair of Removable Dentures	
— Repair denture and replace one broken tooth	$ 17.50
— Replace broken clasp	$ 31.50
Recement Crowns	$ 7.00
Biopsies of Oral Tissue	$ 10.50

Oral Surgery — Additional Basic 11.6321a

— Extraction of tooth, complete bony impaction	$ 52.50
— Alevoplasty, per sextant, in conjunction with extractions	$ 28.00

— Incision and drainage of abscess		
intraoral	$ 28.00	
extraoral	$ 63.00	
— Treatment of Fracture, maxilla, open reduction	$350.00	
— Frenulectomy	$ 24.50	
Apicoectomy (as a separate procedure)	$ 35.00	
Hemisection	$ 35.00	
General Anesthesia	$ 10.50	
Inlays, Onlays, Crowns		
— Gold Inlay, one surface	$ 35.00	
— Onlay, per tooth	$ 66.50	
— Crown, porcelain with metal	$ 91.00	
— Crown, gold (full cast)	$ 63.00	
Dentures		Prosthodontic (optional) 11.6321b
— Complete upper	$164.50	
— Complete lower	$164.50	
— Partial lower (2 clasps, acrylic base, 8 teeth)	$185.50	
Denture Adjustments	$ 7.00	
Denture Relining		
— Complete Denture (office)	$ 17.50	
— Partial Denture (office)	$ 17.50	
Bridges		
— Pontics		
Cast gold $ 70.00		
Porcelain fused to metal	$ 73.50	
— Abutments		
Two surface gold inlay	$ 49.00	
Gold onlay $ 66.50		
— Crowns		
Porcelain fused to metal	$ 91.00	
Gold (full cast) $ 63.00		
Periodontics		Periodontic (optional) 11.6321c
— Special periodontal appliance	$ 35.00	

— Periodontal Prophylaxis	$ 24.50
— Occlusal adjustments	
limited	$ 10.00
complete	$ 15.00
— Cases Types Per Sextant (including all diagnostic, surgical and adjunctive services)	
Type 1—Gingivitis	$ 70.00
Type 2—Early Periodontitis	$ 80.50
Type 3—Moderate Periodontitis	$ 91.00
Type 4—Advanced Periodontitis	$105.00

Orthodontic Case Types — Orthodontic (optional) 11.6321d

(includes diagnostic procedures, appliances and treatment)

— Fixed Appliances	
Permanent or Mixed Dentition	
Class 1 and 2 Malocclusion	$595.00
Class 3 Malocclusion	$700.00
— Removable Appliances	
Primary Dentition	$ 70.00

Oral Examinations	$ 8.00
Prophylaxis	$ 12.00
Topical Fluoride Application	$ 12.00
Sealants	$ 12.00
Radiographs	
— Intraoral, complete series (including bitewings—4)	$ 16.00
— Bitewing, full set	$ 12.50
— Panoramic	$ 16.00
Fillings	
— Amalgam, one surface, primary	$ 10.00
— Amalgam, one surface, permanent	$ 12.00
— Acrylic or Plastic	$ 14.50
Simple Extractions (per tooth)	$ 12.00
Endodontics	
— Pulp Cap, direct	$ 17.50
— Vital Pulpotomy	$ 20.00
— Root Canal Therapy	
one canal	$108.00
two canals	$120.00
Repair of Removable Dentures	
— Repair denture and replace one broken tooth	$ 28.00
— Replace broken clasp	$ 36.00
Recement Crowns	$ 8.00
Biopsies of Oral Tissue	$ 12.00

Oral Surgery — Additional Basic (optional) 11.6322a

— Extraction of tooth, complete bony impaction	$ 80.00
— Alevoplasty, per sextant, in conjunction with	$ 52.00

extractions		
— Incision and drainage of abscess		
intraoral	$ 32.00	
extraoral	$ 80.00	
— Treatment of Fracture, maxilla, open reduction	$400.00	
— Frenulectomy	$ 60.00	
Apicoectomy (as a separate procedure)	$100.00	
Hemisection	$ 40.00	
General Anesthesia	$ 20.00	
Inlays, Onlays, Crowns		
— Gold Inlay, one surface	$ 80.00	
— Onlay, per tooth	$132.00	
— Crown, porcelain with metal	$160.00	
— Crown, gold (full cast)	$120.00	
Dentures		Prosthodontic (optional) 11.6322b
— Complete upper	$272.00	
— Complete lower	$240.00	
— Partial lower (2 clasps, acrylic base, 8 teeth)	$300.00	
Denture Adjustments	$ 8.00	
Denture Relining		
— Complete Denture (office)	$ 60.00	
— Partial Denture (office)	$ 52.00	
Bridges		
— Pontics		
Cast gold	$124.00	
Porcelain fused to metal	$160.00	
— Abutments		
Two surface gold inlay	$ 80.00	
Gold onlay	$132.00	
— Crowns		
Porcelain fused to metal	$160.00	
Gold (full cast)	$124.00	
Periodontics		Periodontic (optional) 11.6322c

— Special periodontal appliance	$ 50.00
— Periodontal Prophylaxis	$ 24.00
— Occlusal adjustments	
limited	$ 12.00
complete	$ 18.00
— Cases Types Per Sextant (including all diagnostic, surgical and adjunctive services)	
Type 1—Gingivitis	$104.00
Type 2—Early Periodontitis	$120.00
Type 3—Moderate Periodontitis	$140.00
Type 4—Advanced Periodontitis	$160.00

Orthodontic Case Types

(includes diagnostic procedures, appliances and treatment) — Orthodontic (optional) 11.6322d

— Fixed Appliances	
Permanent or Mixed Dentition	
Class 1 and 2 Malocclusion	$595.00
Class 3 Malocclusion	$700.00
— Removable Appliances	
Primary Dentition	$ 70.00

Benefit Maximum

The maximum amount that will be paid for you in dental benefits each benefit period is $. This is an individual maximum. There is no family maximum. 11.641

This maximum applies to all of your Dental Covered Services except for Orthodontic Dental Services. Orthodontic Dental Services are subject to a maximum of $ for a course of treatment. 11.642

IMPORTANT INFORMATION ABOUT YOUR DENTAL BENEFITS

Care By More Than One Dentist

If you should change Dentists in the middle of a particular Course of Treatment, benefits will be provided as if you had stayed with the same Dentist until your treatment was completed.

Alternate Benefit Program

In all cases in which there is more than one Course of Treatment possible, the benefit payment will be based upon the least costly Course of Treatment.

Pre-Certification of Benefits

If your Dentist recommends a Course of Treatment that will cost more than $125, your Dentist must prepare a report describing the planned treatment, copies of necessary x-rays, photographs and models and an estimate of the charges for such prior to your beginning the Course of Treatment. Blue Cross and Blue Shield will review the report and materials, taking into consideration alternative adequate Course of Treatment, and will notify you and your Dentist of the benefits which will be provided under this Benefit Section.

Special Limitations

No benefits will be provided under this Benefit Section for:

1. Dental services which are performed for cosmetic purposes, except those made necessary because of an accident occurring on or after your Coverage Date.
2. Appliances or restorations necessary to increase vertical dimensions or restore the occlusion or change the relationship of the mandible to other body members.
3. Oral Surgery services related to a congenital malformation, except when rendered to a newborn.
4. Any services, treatments or supplies included as an eligible benefit under any other Benefit Section of this Certificate.

EXTENSION OF YOUR DENTAL BENEFITS IN CASE OF TERMINATION

If your coverage under this Certificate should terminate, benefits will continue for any dental Covered Services described in this Benefit Section as long as the Covered Service was begun prior to the date your coverage terminated and is completed within 30 days of your termination date.

BENEFITS FOR MEDICARE ELIGIBLE COVERED PERSONS

This section describes the benefits which will be provided for Medicare Eligible Covered Persons who are not affected by MSP laws, unless otherwise specified in this Certificate (see provisions entitled ''Medicare Eligible Covered Persons'' in the ELIGIBILITY SECTION of this Certificate).

The benefits and provisions described throughout this Certificate apply to you, however, in determining the benefits to be paid for your Covered Services, consideration is given to the benefits available under Medicare.

The process used in determining benefits under this Certificate is as follows:

1. determine what the payment for a Covered Service would be following the payment provisions of this Certificate and
2. deduct from this resulting amount the amount paid or payable by Medicare. (If you are eligible for Medicare, the amount that is available from Medicare will be deducted whether or not you have enrolled and/or received payment from Medicare.) The difference, if any, is the amount that will be paid under this Certificate. 9.OC

1. determine payment for services eligible under Medicare by deducting from the total eligible charges, the amount paid by Medicare. The difference, if any, is the amount that will be eligible for payment under this Certificate; and
2. using the amount determined in accordance with step 1 above, determine what the payment for a Covered Service would be following the payment provisions of this Certificate (for example, any applicable deductible and/or Coinsurance will be applied to that amount). The resulting amount will be paid under this Certificate up to the Eligible Charge or Medicare approved amount. 9.OF

1. determine what the payment for a Covered Service would be following the payment provisions of this Certificate.
2. deduct from the charges eligible under Medicare, the amount paid by Medicare.
3. the lesser of the two amounts determined in accordance with step 1 and step 2 above is the amount that will be paid under this Certificate. 9.OK

When you have a Claim, you must send Blue Cross and Blue Shield a copy of your Explanation of Medicare Benefits ("EOMB") in order for your Claim to be processed. In the event you are eligible for Medicare but have not enrolled in Medicare, the amount that would have been available from Medicare, had you enrolled, will be used.

MEDICARE SUPPLEMENTAL BENEFIT SECTION

To determine if this Benefit Section applies to you, refer to the paragraphs in the ELIGIBILITY SECTION of this Certificate entitled "Medicare Eligible Members."

As you know, Medicare was not designed to pay your whole bill when you have health care expenses. The purpose of this coverage is to help you pay for the expenses remaining after Medicare has made its payment. This section of your Certificate describes these supplemental benefits.

In order to make your Medicare Supplemental Benefits more understandable a general explanation of Medicare benefits is included in the description of your benefits below. Of course, it cannot be guaranteed that you will receive the Medicare benefits described. Therefore, if you have any questions regarding Medicare benefits, you should contact your local Social Security Administration office.

The benefits of this section are subject to all of the terms and conditions of this Certificate. Your benefits are also subject to the Pre-Existing Conditions waiting period. Please refer to the DEFINITIONS, ELIGIBILITY and EXCLUSIONS sections of this Certificate for additional information regarding any limitations and/or special conditions pertaining to your benefits. 0.570

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

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

HOSPITAL SERVICES

You are entitled to benefits for the following services when you receive these services from a Hospital or from any other Provider that is specified below.

Inpatient Hospital Covered Services

Benefits will be provided for the Covered Services that you receive from a Hospital when you are an Inpatient.

You are entitled to benefits for 820 days of Inpatient Hospital Care (your "Hospital days"). If you should use all of your Hospital days, they will be reinstated to the full amount each time you are out of the Hospital for 60 days in a row.

Payment for Inpatient Hospital Covered Services

When you are an Inpatient in a Hospital for the first 60 days starting with the day you are admitted, Medicare will pay for all of your covered expenses except for an initial deductible amount. THIS COVERAGE WILL PAY THE AMOUNT OF THAT DEDUCTIBLE FOR YOU.

If you are in the Hospital for more than 60 days, Medicare will no longer pay your covered expenses in full. You will be responsible for paying a set dollar amount for each day that you are in the Hospital. This daily amount is equal to 1/4 of the amount of the Hospital deductible. Medicare will deduct this amount from its payment for each day that you are in the Hospital beginning with the 61st day through the 90th day. THIS COVERAGE WILL PAY THIS DAILY AMOUNT FOR YOU.

Medicare will stop making payment at the 90th day, unless you choose to use your Medicare reserve days. Under Medicare, you have 60 reserve days. You can use these days all at once or a few at a time but they cannot be renewed once you have used them. If you are in the Hospital for more than 90 days and choose to use your reserve days, Medicare will again deduct a daily amount from their payment. This daily amount is equal to 1/2 of the Medicare Inpatient Hospital deductible. THIS COVERAGE WILL PAY THIS DAILY AMOUNT FOR YOU, WHETHER OR NOT YOU CHOOSE TO USE YOUR MEDICARE RESERVE DAYS, BEGINNING WITH THE 91ST DAY. THESE BENEFITS WILL CONTINUE FOR UP TO 820 DAYS.

When you receive Covered Services from a Non-Plan Hospital, benefits will be provided at 50% of the Eligible Charge. 8.1a

When you receive Covered Services from a Non-Plan Hospital, your benefits will be 80% of the amount you would have received had you been in a Plan Hospital. 8.1b

Blood

When you receive blood, Medicare will pay the cost of all but the first 3 pints each year. THIS COVERAGE WILL PAY THE COST OF THE FIRST 3 PINTS FOR YOU, IF NOT REPLACED.

Inpatient Skilled Nursing Facility Covered Services

Your benefits include coverage for the services that you receive from a Skilled Nursing Facility when you are an Inpatient. However, you must have been an Inpatient in a Hospital for at least 3 days and you must be admitted to a Skilled Nursing Facility within 30 days after discharge from that Hospital stay.

You are entitled to benefits for 80 days of Inpatient care beginning with the 21st day after your admission. (Medicare pays in full for the first 20 covered days.) These days are considered part of your Hospital days. This means that: 1) for every day that you use, one day will be deducted from your Hospital days and 2) no days are available if you have used all of your Hospital days. As with your Hospital days, these days will be reinstated to the full amount each time you are out of the Hospital and Skilled Nursing Facility for 60 days in a row.

Payment for Inpatient Skilled Nursing Facility Covered Services

When you are an Inpatient in a Skilled Nursing Facility for the first 20 days beginning with the day you are admitted, Medicare will pay your covered expenses in full.

If you are in the Skilled Nursing Facility for more than 20 days, Medicare will no longer pay your covered expenses in full. You will be responsible for paying a set dollar amount for each day that you are in the facility. This daily amount is equal to 1/8 of the amount of the Hospital deductible. Medicare will deduct this amount from their

payment for each day that you are in the facility beginning with the 21st day through the 100th day. THIS COVERAGE WILL PAY THIS DAILY AMOUNT FOR YOU.

When you receive Covered Services from a Non-Plan Skilled Nursing Facility, benefits will be provided at 50% of the Eligible Charge. Benefits will not be provided for Covered Services received in an Uncertified Skilled Nursing Facility. 8.3a

When you receive Covered Services from a Non-Plan Skilled Nursing Facility, your benefits will be 80% of the amount you would have received had you been in a Plan Skilled Nursing Facility. Benefits will not be provided for Covered Services received in an Uncertified Skilled Nursing Facility. 8.3b

Outpatient Hospital Services

Your benefits include coverage for the following services when you receive these services from a Hospital as an Outpatient.

1. Emergency Accident Care—Treatment must occur within 72 hours of the accident.
2. Emergency Medical Care
3. Surgery and any related Diagnostic Service received on the same day as the Surgery.
4. Radiation therapy treatments
5. Chemotherapy
6. Shock therapy—For each shock treatment received, one day is deducted from your Hospital days.
7. Renal Dialysis Treatment—These treatments are covered if you receive them in a Hospital, a Dialysis Facility or in your home under the supervision of a Hospital or Dialysis Facility. For each renal dialysis treatment you receive, one day is deducted from your Hospital days.

Payment for Outpatient Hospital Covered Services

Under Medicare, Outpatient Hospital services are subject to a deductible each calendar year. After you meet that deductible, Medicare will then pay 80%. UNDER THIS COVERAGE, 100% OF THE ELIGIBLE CHARGE WILL BE PAID FOR OUTPATIENT HOSPITAL COVERED SERVICES IF YOU HAVE NOT YET MET YOUR MEDICARE DEDUCTIBLE. IF YOU HAVE MET YOUR MEDICARE DEDUCTIBLE, THEN BENEFITS WILL BE PROVIDED FOR 20% OF THE ELIGIBLE CHARGE.

When you receive services from a Non-Plan Hospital or other Non-Plan Provider, benefits will be provided at 50% of the Eligible Charge. 8.2a

When you receive services from a Non-Plan Hospital or other Non-Plan Provider, the benefit payment will be 80% of the amount you would have received had you received such services from a Plan Hospital or other Plan Provider. 8.2b

SURGICAL/MEDICAL SERVICES

Your coverage includes benefits for the following services when you receive these services from a Physician. All of these services must be rendered to you by a Physician unless it is specifically stated otherwise in the description of the service.

Surgery

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

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

The following services are also included in your benefits for Surgery:

1. Sterilization Procedures (even if they are elective).
2. Anesthesia Services—if administered at the same time as a covered surgical procedure by a Physician other than the operating surgeon or by a CRNA.
3. Assistant Surgery—services by a Physician, Dentist or Podiatrist who assists the operating surgeon in performing covered Surgery but only if a Hospital intern or resident is not available for such assistance.

Medical Care

Medical Care visits are covered if you are an Inpatient in a Hospital Skilled Nursing Facility or Substance Abuse Treatment Facility.

Your Medical Care benefits include coverage for the following special types of Medical Care:

— Intensive Medical Care—That is, Medical Care rendered in critical cases and which requires special supervision and time by the Physician.

— Psychiatric Care—That is, Medical Care rendered for the treatment of a Mental Illness. This type of care consists only of psychotherapy, group therapy, psychological testing and/or family counseling (interviews with the patient's family to obtain information that will help in treating the patient). In addition to a Physician, psychiatric care rendered by a Psychologist is covered.

Inpatient Consultations

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

Inpatient Electroencephalograms and Electrocardiograms

Your coverage includes benefits for electroencephalograms and electrocardiograms when you receive them as an Inpatient in connection with covered Inpatient Medical Care.

Shock therapy treatments

Radiation therapy treatments

Chemotherapy—benefits will be provided for Chemotherapy except oral Chemotherapy and subcutaneous and intramuscular injections.

X-rays and Clinical and Surgical Pathology

Your coverage includes benefits for x-rays and clinical and surgical pathology if performed on an Outpatient basis. For x-rays to be eligible for benefits, they must be the initial x-rays done in connection with the correction of fractures or complete dislocations. For clinical or surgical pathology to be eligible for benefits, it must be performed in connection with covered Surgery. These services are eligible for benefits whether performed by a Physician or by a Dentist or Podiatrist.

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

Emergency Medical Care

Chiropractic Service—when rendered by a Chiropractor or Physician.

Payment for Surgical/Medical Services

When you receive any of the Surgical/Medical Covered Services described above, benefits will be provided at 20% of the Usual and Customary Fee. (Medicare pays 80% of its allowable charges after a calendar year deductible is met. If Medicare does not pay your charges because your charges have been applied toward your deductible, this coverage will not provide benefits for charges in full for you but will still make the 20% benefit payment toward those charges.)

SPECIAL CONDITIONS

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

Human Organ Transplants

Your coverage includes benefits for certain human organ and tissue transplants. Benefits will be provided only for cornea, kidney, bone marrow, heart valve, muscular-skeletal or parathyroid human organ or tissue transplants. Benefits are available to both the recipient and donor of a covered transplant as follows:

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

— If you are the recipient of the transplant, and the donor for the transplant has no coverage from any other source, the benefits under this Certificate will be provided for both you and the donor. In this case, the number of Hospital days used by the donor will be deducted from your Hospital days.

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

Substance Abuse Rehabilitation Treatment

Benefits for all of the services previously described are available for Substance Abuse Rehabilitation Treatment. In addition, benefits will be provided if these services are rendered by a Substance Abuse Treatment Facility. For benefits to be provided at the Plan Provider payment level, services must be provided by a Blue Cross and Blue Shield approved Substance Abuse Rehabilitation Treatment program of a Plan Hospital or of a Plan Substance Abuse Treatment Facility. Such Plan Provider benefits will be provided at the same level as payment for Covered Services in a Plan Hospital. Benefits will not be provided for Substance Abuse Rehabilitation Treatment in programs which have not been approved in writing by Blue Cross and Blue Shield nor in a Non-Plan Substance Abuse Treatment Facility. However, benefits will be provided for the Inpatient and/or Outpatient Treatment of alcoholism in a non-approved program or a Non-Plan facility at the same level as payment for Non-Plan Hospital services.

IF YOU ARE HOSPITALIZED OUTSIDE THE UNITED STATES

Your Medicare Supplemental coverage provides important benefits for you should you be hospitalized in another country. Benefits will be provided at 100% of the Eligible Charge or Usual and Customary Fee for up to 120 Inpatient Hospital days and 120 Inpatient Medical Care visits. These days and visits are renewed each time you are out of the Hospital or do not receive Inpatient Medical Care visits for 90 days in a row.

EXTENSION OF BENEFITS IN CASE OF TERMINATION

If you are an Inpatient at the time your coverage under this Certificate is terminated, benefits will be provided for, and limited to, the Covered Services which are provided by and regularly charged for by a Hospital, Skilled Nursing Facility or Freestanding Substance Abuse Treatment Facility. These benefits will be provided until you are discharged or until your Hospital days are exhausted, whichever occurs first.

MEDICARE SUPPLEMENT BENEFITS

As you know, Medicare was not designed to pay your whole bill when you have health care expenses. The purpose of this coverage is to help you pay for the expenses remaining after Medicare has made its payment.

In order to make your Medicare Supplement Benefits more understandable a general explanation of Medicare benefits is included in the description of your benefits under this Certificate. Of course, it cannot be guaranteed that you will receive the Medicare benefits described. Therefore, if you have any questions regarding Medicare benefits, you should contact your local Social Security Administration office.

Any benefits designed to cover cost-sharing amounts under Medicare will automatically be changed with any changes in the applicable Medicare deductible or Copayment amounts or Coinsurance percentages.

Your benefits are subject to all of the terms and conditions of this Certificate[, including the Preexisting Conditions waiting period]. Please refer to the DEFINITIONS, ELIGIBILITY and EXCLUSIONS sections of this Certificate for additional information regarding any limitations and/or special conditions pertaining to your benefits. 39.56

In addition, your Medicare Supplement Benefits will be provided only when: **Revised**

— You receive services on or after your Coverage Date;

— Services are rendered upon the direction or under the direct care of a Physician;

— Services are Medically Necessary and regularly included in the Provider's charges; and

— In the case of Medicare Eligible Expenses, services are approved by Medicare or, if you are not enrolled in Medicare, services would have been approved had you enrolled in Medicare.

[**YOUR ANNUAL DEDUCTIBLE** Plan F High Ded.

Each year you must pay a deductible before your benefits will begin under this Certificate. This deductible is referred to as your "Annual Deductible." After you have claims for Medicare Eligible Expenses in a calendar year that are more than $[], your benefits will begin. This deductible is in addition to Medicare Part A and Part B deductibles. The following expenses paid by you can be used to meet the Annual Deductible: **Revised** $ amount specified in regulations

— Medicare Part A deductible.

— Medicare Part B deductible.

— Coinsurance for Medicare eligible covered services.

— Charges for emergency care received in a foreign country that exceed the foreign travel deductible amount.

Medicare may change the Annual Deductible amount each year as specified in Section 1882(p)(11)(c)(i) of the Social Security Act.] 39.1fhd

[YOUR OUT-OF-POCKET LIMIT

Plans K & L

Your coverage under this Certificate has an annual out-of-pocket limit. Once you meet the annual limit, this coverage pays 100% of the Medicare Part A and Part B Copayments, Coinsurance and deductibles for the rest of the calendar year. Charges that exceed Medicare-approved amounts (called "Excess Charges") are not covered and do not count towards the out-of-pocket limit. You will have to pay these Excess Charges.

Your annual out-of-pocket limit is $[]. This amount can increase each year because of inflation.]

$ amount specified in regulations
39.2 **Revised**

INPATIENT HOSPITAL BENEFITS

Your coverage includes benefits for Inpatient services eligible for coverage under Medicare Part A.

INPATIENT HOSPITAL COVERED SERVICES

Benefits will be provided for Inpatient Hospital services only when: **Revised**

1. You receive services on or after your Coverage Date;
2. Services are rendered upon the direction or under the direct care of a Physician;
3. Services are Medically Necessary and regularly included in the Provider's charges; and
4. In the case of Medicare Eligible Expenses, services are approved by Medicare or, if you are not enrolled in Medicare, services would have been approved had you enrolled in Medicare.

Typical Inpatient charges are charges for:

1. Bed, board and general nursing care
2. Other ancillary services, such as:
   - Use of operating and treating rooms
   - Inpatient drugs
   - Surgical dressings
   - Blood processing
   - Diagnostic services
   - Administration of whole blood and blood components, when there is a charge

Payment for Inpatient Hospital Covered Services

When you are an Inpatient in a Hospital for the first 60 days of each Benefit Period, starting with the day you are admitted, Medicare will pay for all of your covered expenses except for an initial deductible amount (the Medicare Part A deductible).

[**This coverage will pay the amount of that deductible for you.**] 39.3 Plans B–F, I, J

[**This coverage will pay 50% of the amount of that deductible for you until the annual out-of-pocket limit is met. Once you reach the annual limit, this coverage will pay 100% of the deductible.**] 39.1k Plan K

[**This coverage will pay 75% of the amount of that deductible for you until the out-of-pocket limit is met. Once you reach the annual limit, this coverage will pay 100% of the deductible.**] 39.1l Plan L

If you are in the Hospital for more than 60 days in a Benefit Period, Medicare will no longer pay your covered expenses in full. You will be responsible for paying a set dollar amount for each day that you are in the Hospital. This daily amount is equal to 1/4 of the Medicare Part A deductible. Medicare will deduct this amount from its pay-

ment for each day that you are in the Hospital beginning with the 61st day through the 90th day.

This coverage will pay this daily amount for you. All Plans

Medicare will stop making payment at the 90th day of a Benefit Period, unless you choose to use your Medicare reserve days. Under Medicare, you have 60 reserve days. You can use these days all at once or a few at a time but they cannot be renewed once you have used them. If you are in the Hospital for more than 90 days and choose to use your reserve days, Medicare will again deduct a daily amount from their payment. This daily amount is equal to 1/2 of the Medicare Part A deductible.

This coverage will pay this daily amount for you (an amount equal to 1/2 of the Medicare Part A deductible), whether or not you choose to use your Medicare reserve days, beginning with the 91st day through the 150th day. Beginning on the 151st day of your Hospital stay, this coverage will pay 100% of the Medicare Eligible Expenses for an additional lifetime maximum of 365 days. **Revised** All Plans

BLOOD

When you receive blood or packed red blood cells at a Hospital or Skilled Nursing Facility, Medicare will pay the cost of all but the first 3 pints each year.

[**This coverage will pay the reasonable cost of the first 3 pints for you, unless you or someone else donates blood to replace what you use.**] 39.4 Plans A–F, I, J

[**If you have met your Annual Deductible, this coverage will pay the reasonable cost of the first 3 pints for you, unless you or someone else donates blood to replace what you use.**] 39.1fhd Plan F High Ded.

[**This coverage will pay 50% of the cost of the first 3 pints for you until the annual out-of-pocket limit is met, unless you or someone else donates blood to replace what you use. Once you reach the annual limit, this coverage will pay 100% of the Medicare Eligible Expenses for the rest of the year.**] 39.1k Plan K

[**This coverage will pay 75% of the cost of the first 3 pints for you until the annual out-of-pocket limit is met, unless you or someone else donates blood to replace what you use. Once you reach the annual limit, this coverage will pay 100% of the Medicare Eligible Expenses for the rest of the year.**] 39.1l Plan L

SKILLED NURSING FACILITY COVERED SERVICES Plans C–F, I–L

Your benefits include coverage for the services that you receive from a Skilled Nursing Facility when you are an Inpatient. However, you must have been an Inpatient in a Hospital for at least 3 days and you must be admitted to a Skilled Nursing Facility within 30 days after discharge from that Hospital stay.

Payment for Skilled Nursing Facility Covered Services

When you are an Inpatient in a Skilled Nursing Facility for the first 20 days beginning with the day you are admitted, Medicare will pay your covered expenses in full.

If you are in the Skilled Nursing Facility for more than 20 days, Medicare will no longer pay your covered expenses in full. You will be responsible for paying a set dollar amount for each day that you are in the facility. This daily amount is equal to 1/8 of the amount of the Medicare Part A deductible. Medicare will deduct this amount from

their payment for each day that you are in the facility beginning with the 21st day through the 100th day. 39.5

[**This coverage will pay this daily amount for you.**] 39.51 Plans C–F, I, J

[**This coverage will pay this daily amount for you after you have met your Annual Deductible.**] 39.1fhd Plan F High Ded.

[**This coverage will pay 50% of this daily amount for you until the annual out-of-pocket limit is met. Once you reach the annual limit, this coverage will pay 100% of the daily amount for the rest of the year.**] 39.1k Plan K

[**This coverage will pay 75% of this daily amount for you until the annual out-of-pocket limit is met. Once you reach the annual limit, this coverage will pay 100% of the daily amount for the rest of the year.**] 39.1l Plan L

[**HOSPICE CARE** Plans K & L

Your benefits include coverage for hospice care and Inpatient respite care if you are getting Medicare-approved hospice care. You can stay in a Medicare-approved facility, such as a hospice facility, Hospital or nursing home, up to 5 days each time you get respite care. There is no limit on the number of times you can get respite care.

Payment for Hospice Care

Medicare will pay all your costs for eligible hospice services except for a copayment amount for outpatient prescription drugs. Medicare will pay 95% of its approved amount for Inpatient respite care. 39.20

[**This coverage will pay 100% of your coinsurance or copayment amounts for all Medicare Eligible Expenses.**] 39.1AF Plans A & F

[**This coverage will pay 100% of your coinsurance or copayment amounts for all Medicare Eligible** [**after you have met your annual deductible.**]] Plan F High Ded.

[**This coverage will pay 50% of your coinsurance or copayment amounts for all Medicare Eligible Expenses until the annual out-of-pocket limit is met. Once you reach the annual limit, this coverage will pay 100% of your coinsurance and copayments for the rest of the year.**] 39.1k Plan K

[**This coverage will pay 75% of your coinsurance or copayment amounts for all Medicare Eligible Expenses until the annual out-of-pocket limit is met. Once you reach the annual limit, this coverage will pay 100% of your coinsurance and copayments for the rest of the year.**]] 39.1l Plan L

MEDICAL BENEFITS

Your coverage includes benefits for the medical expenses eligible for coverage under Medicare Part B when you receive these services from a properly licensed medical professional or a Hospital on an Outpatient basis only when: **Revised**

1. You receive services on or after your Coverage Date;
2. Services are rendered upon the direction or under the direct care of a Physician;
3. Services are Medically Necessary and regularly included in the Provider's charges; and
4. In the case of Medicare Eligible Expenses, services are approved by Medicare or, if you are not enrolled in Medicare, services would have been approved had you enrolled in Medicare.

Benefits are available for the following medical expenses:

Surgery and Anesthesia

Benefits are available for surgery in or out of the Hospital. This includes surgery in a licensed facility specializing in outpatient surgery.

Your benefits include anesthesia administered on an Outpatient basis by a medical provider other than the operating surgeon.

Medical Care

Benefits are available for all Medicare-approved medical care visits in your Physician's office, in a Hospital or Skilled Nursing Facility, in your home or in any other location.

Additional Surgical Opinions

Your coverage includes benefits for second surgical opinions by a Physician in some cases. In certain circumstances, a third opinion may be covered. **Revised**

Ambulance Services

Blood

Your benefits include coverage for the reasonable cost of the first 3 pints of blood or packed red blood cells each year, unless you or someone else donates blood to replace what you use.

Chiropractic Services

Diabetes Supplies and Services

Diagnostic Tests

Your coverage includes benefits for X-rays, MRIs, CT scans, EKGs, and some other diagnostic tests if Medically Necessary.

Durable Medical Equipment

Kidney Dialysis Services

Your coverage includes benefits for Outpatient kidney dialysis and related services and supplies, either in a facility or at home.

Outpatient Hospital Services

Outpatient Mental Health Care

Outpatient mental health care includes visits with a Physician, clinical psychologist, clinical social worker, or other qualified mental health professional and lab tests. Your coverage also includes partial hospitalization services if you need intensive coordinated Outpatient care to help you avoid Inpatient treatment.

Outpatient Occupational, Physical and Speech Therapy

Preventive Medical Care

The following preventive tests and services are covered: **Revised**

1. Bone mass measurement
2. Colorectal cancer screening
3. Diabetes services
4. Glaucoma testing
5. Pelvic examination
6. Prostate cancer screening
7. Screening mammograms
8. Vaccinations

Prosthetic Devices

Prosthetic devices needed to replace a body part or function are covered. These include cataract lenses, ostomy bags and certain related supplies, and breast prostheses (including a surgical brassiere) after a mastectomy.

Radiation Therapy and Chemotherapy

Transplant Services

You are covered for certain human organ and tissue transplants.

PAYMENT FOR MEDICAL SERVICES

Under Medicare, medical expenses are subject to the Medicare Part B deductible each calendar year. After you meet that deductible, Medicare pays 80% of its allowable charges.

[Under this coverage, 20% of the Medicare Eligible Expenses will be paid for medical services after you have met your Medicare Part B deductible.] 39.7 Plans A, B, D, E, I

[**Under this coverage, 100% of the Medicare Eligible Expenses will be paid for medical services until you have met your Medicare Part B deductible. Once you have met this deductible, 20% of the Medicare Eligible Expenses will be paid for medical services.**] 39.71 Plans C, F, J

[**Under this coverage, after you have met your Annual Deductible, 100% of the Medicare Eligible Expenses will be paid for medical services until you have met your Medicare Part B deductible. Once you have met this deductible, 20% of the Medicare Eligible Expenses will be paid for medical services.**] 39.1fhd Plan F High Ded.

[[**Also, this coverage will pay any Medicare Part B Excess Charges.**] 39.73 Plans F, I & J

[**Also, this coverage will pay any Medicare Part B Excess Charges after you have met your Annual Deductible.**] 39.1fhd Plan F High Ded.

"Excess Charges" are the difference between the billed charge and the Medicare-approved amount, up to the Limiting Charge established by law. The Limiting Charge for a service is shown on your Medicare Summary Notice ("MSN") as the amount "You May Be Billed."] 39.72

[[**Under this coverage, 10% of the Medicare Eligible Expenses will be paid for medical services after you have met your Medicare Part B deductible.**] **Once you reach the annual out-of-pocket limit, this coverage will pay 100% of any remaining Medicare Eligible Expenses for the rest of the year.** 39.1k Plan K

[**Under this coverage, 15% of the Medicare Eligible Expenses will be paid for medical services after you have met your Medicare Part B deductible.**] 39.1l Plan L

However, this coverage will pay any remaining Medicare Eligible Expenses in full for any preventive medical care services covered under Part B.] 39.2 Plans K & L

Outpatient Prospective Payment System

The Outpatient Prospective Payment System consists of specific payment amounts set by Medicare for certain Outpatient services you receive from a Hospital, community mental health center, or other entity providing Outpatient services. Medicare has also set a specific Copayment amount that must be paid for these services. Before receiving an Outpatient service you should check with your Physician or Hospital to see if it will be paid under the Outpatient Prospective Payment System.

[**Under this coverage, the Outpatient Prospective Payment System Copayment amount will be paid.**] 39.4 Plans A–F, I, J

[**Under this coverage, the Outpatient Prospective Payment System Copayment amount will be paid after you have met your Annual Deductible.**] 39.1fhd Plan F High Ded.

[**Under this coverage, 50% of the Copayment amount under the Outpatient Prospective Payment System will be paid until the annual out-of-pocket limit is met. Once you reach the annual limit, this coverage will pay 100% of your Copayments for the rest of the year.**] 39.1k Plan K **Revised**

[**Under this coverage, 75% of the Copayment amount under the Outpatient Prospective Payment System will be paid until the annual out-of-pocket limit is met. Once you reach the annual limit, this coverage will pay 100% of your Copayments for the rest of the year.**] 39.1l Plan L

[SPECIAL CONDITIONS AND PAYMENTS

39.9 All Plans except A, B, K & L

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

[EMERGENCY CARE IN A FOREIGN COUNTRY

Plans C, D, E, F, F High Ded., I, J

Benefits will be provided for Medically Necessary emergency Hospital, Physician and medical care received in a foreign country if the care would have been covered by Medicare had it been provided in the United States. The emergency care must begin during the first 60 days of your trip because of an injury or illness of sudden and unexpected onset.

Payment for Emergency Care in a Foreign Country

Generally, Medicare pays nothing for emergency health care outside the United States.

Under this coverage, benefits will be provided at 80% of the Eligible Charges after you have met a calendar year deductible of $250 of emergency care services received in a foreign country.

There is a $50,000 lifetime benefit maximum for emergency care in a foreign country.]

39.91

[AT-HOME RECOVERY

Plans D, I & J

Your benefits include coverage for services that provide short term, at-home assistance with activities of daily living if you are recovering from an illness, injury or surgery.

Your at-home recovery benefits are subject to the following rules:

1. At-home recovery services must be provided to primarily assist you in activities of daily living (such as bathing, dressing, and eating).
2. Benefits will only be provided if at-home recovery visits are received at the same time you are receiving Medicare-approved home care services or no more than 8 weeks after the last service date of a Medicare-approved home health care visit.
3. At-home recovery visits must be made by a Care Provider. A “Care Provider” means an individual employed by an organization that is a Medicare certified home health agency, and is accredited through a national accrediting organization such as the Joint Commission on Accreditation of Health Organizations (JCAHO), the National League for Nursing (NLN), or the National Home Care Council (NHCC), and is licensed where state law requires. Benefits will not be provided for at-home recovery care provided by family members, unpaid volunteers or providers who are not Care Providers.
4. An “at-home recovery visit” is defined as the period of time required to provide at-home recovery care. Each consecutive 4-hour visit by a Care Provider during a 24-hour period is considered one visit.

5. Your Physician must certify that the specific type and frequency of at-home services are necessary because of a condition for which a home care plan of treatment was approved by Medicare.

Payment for At-Home Recovery

Medicare pays nothing for at-home recovery services.

Under this coverage, at-home recovery benefits are limited to the following benefit maximums:

— **The actual charges for each at-home recovery visit by a Care Provider up to $40 for each visit.**

— **7 at-home recovery visits each week. However, the total number of at-home recovery visits will never exceed the number of Medicare-approved home care service visits.**

— **$1,600 each calendar year.**] 39.92

[**PREVENTIVE MEDICAL CARE** Plans E & J

In addition, coverage will be provided for the following preventive medical care services not covered by Medicare:

1. An annual clinical preventive medical history and physical examination, including patient education to address preventive health care measures.
2. Preventive screening tests or preventive services which are determined to be medically appropriate by your Physician.

Payment for Preventive Medical Care

Medicare pays nothing for these preventive medical care services.

Under this coverage, benefits will be provided for 100% of the Medicare-approved amount for each preventive medical care service, up to a maximum benefit of $120 each calendar year for all preventive medical care.]] 39.93

EXCLUSIONS—WHAT IS NOT COVERED

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

— **Hospitalization, services or supplies which are not Medically Necessary.**
PLEASE NOTE THAT IN ORDER TO PROVIDE YOU WITH HEALTH CARE BENEFITS AT A REASONABLE COST, THE CERTIFICATE PROVIDES BENEFITS ONLY FOR THOSE COVERED SERVICES FOR ELIGIBLE HOSPITALIZATION, CARE, TREATMENT, SERVICES AND SUPPLIES THAT ARE MEDICALLY NECESSARY. IT DOES NOT PAY THE COST OF HOSPITALIZATION OR ANY OTHER HEALTH CARE SERVICES AND SUPPLIES THAT BLUE CROSS AND BLUE SHIELD DETERMINES WERE NOT MEDICALLY NECESSARY.

No benefits will be provided for services which are not, in the reasonable judgment of Blue Cross and Blue Shield, Medically Necessary. Medically Necessary means that a specific service provided to you is reasonably required, in the reasonable judgment of Blue Cross and Blue Shield, for the treatment or management of a medical symptom or condition and that the service provided is the most efficient and economical service which can safely be provided to you. When applied to Hospital Inpatient services, Medically Necessary means that your medical symptoms or condition require that the treatment be provided to you as an Inpatient and that treatment cannot be safely provided to you as an Outpatient. Further, Medically Necessary means that Inpatient Hospital care and treatment will not be covered when, in the reasonable judgment of Blue Cross and Blue Shield, your medical symptoms and condition no longer necessitate your continued stay in a Hospital. The fact that a Physician or other health care Provider may prescribe, order, recommend or approve a service or supply does not of itself make such a service Medically Necessary.] 0.61

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

— **Dental procedures which are not Medically Necessary.**
PLEASE NOTE THAT IN ORDER TO PROVIDE YOU WITH DENTAL CARE BENEFITS AT A REASONABLE COST, THE CERTIFICATE PROVIDES BENEFITS ONLY FOR THOSE COVERED SERVICES FOR ELIGIBLE DENTAL TREATMENT THAT ARE MEDICALLY NECESSARY. IT DOES NOT PAY THE COST OF ANY DENTAL CARE PROCEDURES THAT BLUE CROSS AND BLUE SHIELD DETERMINES WERE NOT MEDICALLY NECESSARY.

No benefits will be provided for procedures which are not, in the reasonable judgment of Blue Cross and Blue Shield, Medically Necessary. Medically Necessary means that a specific procedure provided to you is reasonably required, in the reasonable judgment of Blue Cross and Blue Shield, for the treatment or management of a dental symptom or condition and that the procedure performed is the most efficient and economical procedure which can safely be provided to you. The fact that a Physician or Dentist may prescribe, order, recommend or approve a procedure does not of itself make such a procedure or supply Medically Necessary.][0.61

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

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

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

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

— Hospital admissions for or consisting primarily of observation and/or evaluation that could have been provided safely and adequately in some other setting, e.g., a Physician's office or Hospital Outpatient department.

— Hospital admissions primarily for diagnostic studies (x-ray, laboratory and pathological services and machine diagnostic tests) which could have been provided safely and adequately in some other setting, e.g., Hospital Outpatient department or Physician's office.

— Continued Inpatient Hospital care, when the patient's medical symptoms and condition no longer require their continued stay in a Hospital.

— Hospitalization or admission to a Skilled Nursing Facility, nursing home or other facility for the primary purposes of providing Custodial Care Service, convalescent care, rest cures or domiciliary care to the patient.

— Hospitalization or admission to a Skilled Nursing Facility for the convenience of the patient or Physician or because care in the home is not available or is unsuitable.

— The use of skilled or private duty nurses to assist in daily living activities, routine supportive care or to provide services for the convenience of the patient and/or his family members.

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

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

The fact that your Physician may prescribe, order, recommend, approve or view hospitalization or other health care services and supplies as Medically Necessary does not make the hospitalization, services or supplies Medically

Necessary and does not mean that Blue Cross and Blue Shield will pay the cost of the hospitalization, services or supplies.

If your Claim for benefits is denied on the basis that the services or supplies were not Medically Necessary, and you disagree with Blue Cross and Blue Shield's decision, your policy provides for an appeal of that decision. You must exercise your right to this appeal as a precondition to the taking of any further action against Blue Cross and Blue Shield, either at law or in equity. To initiate your appeal, you must give Blue Cross and Blue Shield written notice of your intention to do so within 180 days after you have been notified that your Claim has been denied by writing to:

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

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

REMEMBER, EVEN IF YOUR PHYSICIAN PRESCRIBES, ORDERS, RECOMMENDS, APPROVES OR VIEWS HOSPITALIZATION OR OTHER HEALTH CARE SERVICES AND SUPPLIES AS MEDICALLY NECESSARY, BLUE CROSS AND BLUE SHIELD WILL NOT PAY FOR THE HOSPITALIZATION, SERVICES AND SUPPLIES IF IT DECIDES THEY WERE NOT MEDICALLY NECESSARY.][0.62

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

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

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

— Hospital admissions for or consisting primarily of observation and/or evaluation that could have been provided safely and adequately in some other setting, e.g., a Physician's office or Hospital Outpatient department.

— Hospital admissions primarily for diagnostic studies (x-ray, laboratory and pathological services and machine diagnostic tests) which could have been provided safely and adequately in some other setting, e.g., Hospital Outpatient department or Physician's office.

— Continued Inpatient Hospital care, when the patient's medical symptoms and condition no longer require their continued stay in a Hospital.

— Hospitalization or admission to a Skilled Nursing Facility, nursing home or other facility for the primary purposes of providing Custodial Care Service, convalescent care, rest cures or domiciliary care to the patient.

— Hospitalization or admission to a Skilled Nursing Facility for the convenience of the patient or Physician or because care in the home is not available or is unsuitable.

— The use of skilled or private duty nurses to assist in daily living activities, routine supportive care or to provide services for the convenience of the patient and/or his family members.

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

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

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

If your Claim for benefits is denied on the basis that the services or supplies were not Medically Necessary, and you disagree with Blue Cross and Blue Shield's decision, your policy provides for an appeal of that decision. You must exercise your right to this appeal as a precondition to the taking of any further action against Blue Cross and Blue Shield, either at law or in equity. To initiate your appeal, you must give Blue Cross and Blue Shield written notice of your intention to do so within 180 days after you have been notified that your Claim has been denied by writing to:

Claim Review Section
Health Care Service Corporation
Administrator: Hallmark Services Corp.
P.O. Box 2037
Aurora, Illinois 60507-2037

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

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

HOSPITALIZATION, SERVICES AND SUPPLIES IF IT DECIDES THEY WERE NOT MEDICALLY NECESSARY.][0.62 SG

PLEASE NOTE THAT IN ORDER TO PROVIDE YOU WITH BENEFITS AT A REASONABLE COST, THE CERTIFICATE PROVIDES BENEFITS ONLY FOR THOSE ELIGIBLE PRESCRIPTION DRUGS OR SUPPLIES THAT ARE MEDICALLY NECESSARY. IT DOES NOT PAY THE COST OF ANY PRESCRIPTION DRUGS OR SUPPLIES THAT BLUE CROSS AND BLUE SHIELD DETERMINES WERE NOT MEDICALLY NECESSARY.

No benefits will be provided for prescription drugs or supplies which are not, in the reasonable judgment of Blue Cross and Blue Shield, Medically Necessary. Medically Necessary means that a specific prescription drug or supply provided to you is reasonably required, in the reasonable judgment of Blue Cross and Blue Shield, for the treatment or management of a symptom or condition. The fact that a Physician or other health care Provider may prescribe, order, recommend or approve a drug or supply does not of itself make such a drug or supply Medically Necessary.]

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

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

— Services or supplies that are furnished to you by the local, state or federal government and for any services or supplies to the extent payment or benefits are provided or available from the local, state or federal government (for example, Medicare) whether or not that payment or benefits are received, except however, this exclusion shall not be applicable to medical assistance benefits under Article V or VI of the Illinois Public Aid Code (305 ILCS 5/5-1 et seq. or 5/6-1 et seq.) or similar legislation of any state, benefits provided in compliance with the Tax Equity and Fiscal Responsibility Act or as otherwise provided by law.

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

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

— [Investigational Services and Supplies and all related services and supplies, except as may be provided under this Certificate for a) the cost of routine patient care associated with Investigational cancer treatment, if those services or supplies would otherwise be covered under this Certificate if not provided in connection with an approved clinical trial program and b) applied behavior analysis used for the treatment of Autism Spectrum Disorder(s).] **Revised 10/09**

— Custodial Care Service.][

— Long Term Care Service.][

— Respite Care Service, except as specifically mentioned under the Hospice Care Program.][

— Inpatient Private Duty Nursing Service.][

— Routine physical examinations, unless otherwise specified in this Certificate.][

— [Services or supplies received during an Inpatient stay when the stay is solely related to behavioral, social maladjustment, lack of discipline or other antisocial actions which are not specifically the result of Mental Illness. This does not include services or supplies provided for the treatment of an injury resulting from an act of domestic violence or a medical condition (including both physical and mental health conditions.)][**Revised**

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

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

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

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

— Special braces, splints, specialized equipment, appliances, ambulatory apparatus, [medical equipment,]battery implants, except as specifically mentioned in this Certificate.][0.611

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

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

— Treatment of flat foot conditions and the prescription of supportive devices for such conditions and the treatment of subluxations of the foot.][

— Routine foot care, except for persons diagnosed with diabetes.][

— Immunizations, unless otherwise specified in this Certificate.][

— Maintenance Occupational Therapy, Maintenance Physical Therapy and Maintenance Speech Therapy, except as specifically mentioned in this Certificate.][

— Maintenance Care.][

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

— Habilitative Services that are solely educational in nature or otherwise paid under State or Federal law for purely educational services.][**New 10/09**

— Hearing aids or examinations for the prescription or fitting of hearing aids, unless otherwise specified in this Certificate.][	
— Services and supplies to the extent benefits are duplicated because the spouse, parent and/or child are employees of the Group and each is covered separately under this Certificate.][	0.67a
— Services and supplies to the extent benefits are duplicated because the spouse, parent and/or child are covered separately under this Certificate.][	0.67b
— Diagnostic Service as part of routine physical examinations or check-ups, premarital examinations, determination of the refractive errors of the eyes, auditory problems, surveys, casefinding, research studies, screening, or similar procedures and studies, or tests which are Investigational unless otherwise specified in this Certificate.][	
— Residential Treatment Centers.][	
— Procurement or use of prosthetic devices, special appliances and surgical implants which are for cosmetic purposes, the comfort and convenience of the patient, or unrelated to the treatment of a disease or injury.][	
— Wigs (also referred to as cranial prostheses), unless otherwise specified in this Certificate.][	
— Services and supplies rendered or provided for human organ or tissue transplants other than those specifically named in this Certificate.][	
— Elective abortions.][	0.63
— Elective sterilizations.][	0.64a
— Reversals of elective sterilization.][	0.612
— Sterilizations.][	0.64b
— Reversals of sterilization.][	0.613
— Services and supplies rendered or provided for the diagnosis and/or treatment of infertility including, but not limited to, Hospital services, Medical Care, therapeutic injections, fertility and other drugs, Surgery, artificial insemination and all forms of in-vitro fertilization.][	0.65
— Maternity Service, including related services and supplies.][	0.66
— Services and appliances rendered or provided for the diagnosis and/or treatment of Temporomandibular Joint Dysfunction and Related Disorders.][	0.68
— Outpatient Medical Care.][	0.69
— Emergency Medical Care unless such care is followed by an Inpatient admission to a Hospital within 72 hours of the care.][	0.70
— Outpatient prescription drugs or medicines except for immunosuppressive drugs prescribed in connection with a human organ transplant.][	0.71
— Services or supplies rendered for the treatment of Mental Illness or Substance Abuse Rehabilitation Treatment.][	0.72
— Private Duty Nursing.][	0.73

— Outpatient Diagnostic Services except when rendered on the same day as and in connection with Surgery or as part of covered Emergency Accident Care or Emergency Medical Care.][	0.74
— Outpatient Occupational Therapy, Physical Therapy and Speech Therapy.][	0.75
— Surgery for morbid obesity (including, but not limited to, bariatric Surgery).][	0.614
— Gender reassignment Surgery (also referred to as transsexual Surgery, sex reassignment Surgery or intersex Surgery), including related services and supplies.]	0.615
— Repair and replacement for appliances and/or devices due to misuse or loss, except as specifically mentioned in this Certificate.]	**New**

EXCLUSIONS – WHAT IS NOT COVERED

This Certificate does not cover expenses for the following:

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

No benefits will be provided for services which are not, in the reasonable judgment of Blue Cross and Blue Shield, Medically Necessary. Medically Necessary means that a specific medical, health care or Hospital service is required, in the reasonable medical judgment of Blue Cross and Blue Shield, for the treatment or management of a medical symptom or condition and that the service or care provided is the most efficient and economical service which can safely be provided. FOR MEDICARE-APPROVED SERVICES, BLUE CROSS AND BLUE SHIELD WILL NEVER USE STANDARDS MORE RESTRICTIVE THAN MEDICARE.

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

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

— Hospital admissions for or consisting primarily of observation and/or evaluation that could have been provided safely and adequately in some other setting, e.g., a Physician's office or Hospital Outpatient department.

— Hospital admissions primarily for diagnostic studies (x-ray, laboratory and pathological services and machine diagnostic tests) which could have been provided safely and adequately in some other setting, e.g., Hospital Outpatient department or Physician's office.

— Continued Inpatient Hospital care, when the patient's medical symptoms and condition no longer require their continued stay in a Hospital.

— Hospitalization or admission to a Skilled Nursing Facility, nursing home or other facility for the primary purposes of providing Custodial Care Service, convalescent care, rest cures or domiciliary care to the patient.

— Hospitalization or admission to a Skilled Nursing Facility for the convenience of the patient or Physician or because care in the home is not available or is unsuitable.

— The use of skilled or private duty nurses to assist in daily living activities, routine supportive care or to provide services for the convenience of the patient and/or his family members.

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

Blue Cross and Blue Shield will make the decision whether hospitalization or other health care services or supplies were not Medically Necessary and therefore not eligible for payment under the terms of your Certificate. In most instances this decision is made by Blue Cross and Blue Shield AFTER YOU

HAVE BEEN HOSPITALIZED OR HAVE RECEIVED OTHER HEALTH CARE SERVICES OR SUPPLIES AND AFTER A CLAIM FOR PAYMENT HAS BEEN SUBMITTED.

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

If your Claim for benefits is denied on the basis that the services or supplies were not Medically Necessary, and you disagree with Blue Cross and Blue Shield's decision, your policy provides for an appeal of that decision. You must exercise your right to this appeal as a precondition to the taking of any further action against Blue Cross and Blue Shield, either at law or in equity. To initiate your appeal, you must give Blue Cross and Blue Shield written notice of your intention to do so within 180 days after you have been notified that your Claim has been denied by writing to:

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

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

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

— Employment-related injuries or illness if related to work or covered by an insurance or workers' compensation law. This is true even if you decide not to claim benefits under the law.

— Treatment covered or provided by government programs. The only exception is for medical assistance under Article V or VI of the Illinois Public Aid Code.

— Treatment of war-related injuries or illnesses. This exclusion applies to injuries or illnesses caused by war or acts of war, whether declared or undeclared.

— Investigational treatments.

— Free treatment, or treatment that would have been free if you were not insured under this Certificate.[

— Custodial care at home or in a nursing home. Custodial care means services which do not require technical skills or professional training. Assistance with with activities of daily living (such as bathing, feeding, and meal preparation) that is not part of an approved at–home recovery benefit is an example of custodial care.][

Plan D, G, I & J
38.1a

— Custodial care at home or in a nursing home. Custodial care means services which do not require technical skills or professional training. Assistance with with activities of daily living (such as bathing, feeding, and meal preparation) is an example of custodial care.]	**All Plans Except D & J** 38.1b
— Services you no longer need.[	
— Routine physical examinations.]	**All Plans Except E & J** 38.2
— Cosmetic surgery unless it is needed because of accidental injury or to improve the function of a malformed part of the body.	
— Eye examinations, eyeglasses, or contact lenses.	
— Hearing aids or exams for their prescription and fitting.	
— Long term care.	
— Routine foot care, except for those diagnosed with diabetes.	
— Treatment of flat feet or subluxations of the foot.	
— Charges for failure to keep a scheduled appointment or charges for completion of a claim form.	
— Services performed by a member of your immediate family.	
— Outpatient prescription drugs[except as covered under the hospice care benefit].	**Plans K & L include exception** 38.3
— Private duty nursing services.[	
— Skilled Nursing Facility services.][	**Plans A & B** 38.4
— Amounts in excess of the Medicare Eligible Expense.][	**All Plans except F, I & J** 38.5
— Services received in a foreign country.][	**Plans A, B, K & L** 38.6
— At-home recovery services.][	**All Plans except D, I & J** 38.1b
— Preventive medical care not covered by Medicare.]	**All Plans except E & J** 38.2

COORDINATION OF BENEFITS SECTION

[NOTE: If your Group purchased this coverage in conjunction with a Health Savings Account, this COORDINATION OF BENEFITS SECTION does not apply to you.] 0.722

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 Benefit Section.] 0.721

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 Blue Cross and Blue Shield 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.] 0.723

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. Blue Cross and Blue Shield has the right to decide which facts it needs. It may get needed facts from or give them to any other organization or person. Blue Cross and Blue Shield need not tell, or get the consent of, any person to do this. Each person claiming benefits under this Benefit Program must give Blue Cross and Blue Shield 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, Blue Cross and Blue Shield 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. Blue Cross and Blue Shield 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 Blue Cross and Blue Shield 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.

CONTINUATION OF 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 (see definitions) at the time of termination. The provisions described in Article B will apply if you are the spouse of a retired Eligible Person and at least 55 years of age or 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, Surgical-Medical and/or Major Medical 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 insured under the Group Policy (or for similar benefits under any group policy which it replaced) for at least 3 months prior to your termination date or reduction in hours below the minimum required for eligibility. **Revised**

2. Continuation of coverage will not be available to you if: (a) you are covered by Medicare, except if you have been covered under a group Medicare supplement policy, 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 Blue Cross and Blue Shield on a ''direct pay'' basis. **Revised**

3. If you decide to become a member of Blue Cross and Blue Shield 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, the provisions of this Certificate pertaining to ''Extension of Benefits in Case of Termination'' will apply and 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 Blue Cross and Blue Shield for your continued coverage, including any portion of the charge previously paid by your Group. Payment of this charge must be made to Blue Cross and Blue Shield (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 Blue Cross and Blue Shield 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. The date 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. When your continuation of coverage period has expired, the provisions of this Certificate entitled EXTENSION OF BENEFITS IN CASE OF TERMINATION (when applicable) will apply to you.

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 Blue Cross and Blue Shield 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, Blue Cross and Blue Shield 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. Blue Cross and Blue Shield'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 Blue Cross and Blue Shield.

3. In the event you fail to provide written notice to Blue Cross and Blue Shield 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 Blue Cross and Blue Shield 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 Blue Cross and Blue Shield'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 Blue Cross and Blue Shield 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 Blue Cross and Blue Shield 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 Blue Cross and Blue Shield 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, Blue Cross and Blue Shield will advise you at your residence, by certified mail, return receipt requested, that your coverage under this Certificate may be continued. Blue Cross and Blue Shield'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 Blue Cross and Blue Shield.
4. In the event you, or the responsible adult acting on your behalf as the dependent child, fail to provide written notice to Blue Cross and Blue Shield 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 Blue Cross and Blue Shield 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 Blue Cross and Blue Shield'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 Blue Cross and Blue Shield 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 Blue Cross and Blue Shield 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.

CONTINUATION OF COVERAGE AFTER TERMINATION (Illinois State Laws)

[This CONTINUATION OF COVERAGE AFTER TERMINATION section does not apply to Domestic Partners and their children.] **New**

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 (see definitions) at the time of termination. The provisions described in Article B will apply if you are the spouse of a retired Eligible Person and at least 55 years of age or 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, Surgical-Medical and/or Major Medical 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 insured under the Group Policy (or for similar benefits under any group policy which it replaced) 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, except if you have been covered under a group Medicare supplement policy, 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 Blue Cross and Blue Shield on a ''direct pay'' basis.

3. If you decide to become a member of Blue Cross and Blue Shield 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, the provisions of this Certificate pertaining to ''Extension of Benefits in Case of Termination'' will apply and you may exercise the Conversion Privilege explained in the ELIGIBILITY SECTION of this Certificate.

4. Within 10 days of your 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 30 days after your coverage has terminated or reduction in hours below the minimum required for eligibility or 30 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. **Revised 9/09**

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 Blue Cross and Blue Shield for your continued coverage, including any portion of the charge previously paid by your Group. Payment of this charge must be made to Blue Cross and Blue Shield (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 Blue Cross and Blue Shield 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. The date twelve 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. **Revised 9/09**

   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. When your continuation of coverage period has expired, the provisions of this Certificate entitled EXTENSION OF BENEFITS IN CASE OF TERMINATION (when applicable) will apply to you.

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 Blue Cross and Blue Shield 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, Blue Cross and Blue Shield 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. Blue Cross and Blue Shield'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 Blue Cross and Blue Shield.

3. In the event you fail to provide written notice to Blue Cross and Blue Shield 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 Blue Cross and Blue Shield 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 Blue Cross and Blue Shield'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 Blue Cross and Blue Shield 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 Blue Cross and Blue Shield 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 Blue Cross and Blue Shield 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, Blue Cross and Blue Shield will advise you at your residence, by certified mail, return receipt requested, that your coverage under this Certificate may be continued. Blue Cross and Blue Shield'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 Blue Cross and Blue Shield.
4. In the event you, or the responsible adult acting on your behalf as the dependent child, fail to provide written notice to Blue Cross and Blue Shield 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 Blue Cross and Blue Shield 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 Blue Cross and Blue Shield'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 Blue Cross and Blue Shield 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 Blue Cross and Blue Shield 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.

CONTINUATION OF COVERAGE AFTER TERMINATION (Illinois State Law)

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 former spouse of an Eligible Person who has died or from whom you have been divorced. The provisions described in Article B 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 A.

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 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 Blue Cross and Blue Shield 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, Blue Cross and Blue Shield 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. Blue Cross and Blue Shield'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 Blue Cross and Blue Shield.

3. In the event you fail to provide written notice to Blue Cross and Blue Shield 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 Blue Cross and Blue Shield 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 Blue Cross and Blue Shield'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 Blue Cross and Blue Shield 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. 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 B: **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 A 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 Blue Cross and Blue Shield 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, Blue Cross and Blue Shield will advise you at your residence, by certified mail, return receipt requested, that your coverage under this Certificate may be continued. Blue Cross and Blue Shield'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 Blue Cross and Blue Shield.

4. In the event you, or the responsible adult acting on your behalf as the dependent child, fail to provide written notice to Blue Cross and Blue Shield 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 Blue Cross and Blue Shield 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 Blue Cross and Blue Shield'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 Blue Cross and Blue Shield 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 Blue Cross and Blue Shield 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.

CONTINUATION COVERAGE RIGHTS UNDER COBRA

[This CONTINUATION COVERAGE RIGHTS UNDER COBRA section does not apply to Domestic Partners and their children.] **New**

NOTE: Certain employers may not be affected by CONTINUATION OF COVERAGE RIGHTS UNDER COBRA. See your employer or Group Administrator should you have any questions about COBRA. **Revised**

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? **Revised**

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. 13.6

Information about the plan and COBRA continuation coverage can be obtained on request by contacting: 13.7

CONTINUATION OF COVERAGE FOR DOMESTIC PARTNERS

The purpose of this section of your Certificate is to explain the options available for temporarily continuing your coverage after termination, if you are covered under this Certificate as the Domestic Partner of an Eligible Person or as the dependent child of a Domestic Partner. Your continued coverage under this Certificate will be provided only as specified below. Please read the provisions very carefully.

Continuation of Coverage

If you are the Domestic Partner or the dependent child of a Domestic Partner and you lose coverage under this Certificate, you have the same options as the spouse or dependent child of an Eligible Person to continue your coverage. The options available to a spouse or a dependent child are described in the CONTINUATION OF COVERAGE AFTER TERMINATION (Illinois State Laws) section and the CONTINUATION COVERAGE RIGHTS UNDER COBRA section, if applicable to your Group.

NOTE: Certain employers may not be required to offer COBRA continuation coverage. See your Group Administrator if you have any questions about COBRA.

In addition to the events listed in the CONTINUATION OF COVERAGE AFTER TERMINATION (Illinois State Laws) section and the CONTINUATION COVERAGE RIGHTS UNDER COBRA section, if applicable, continuation of coverage is available to you and your dependent children in the event you lose coverage because your Domestic Partnership with the Eligible Person terminates. Your Domestic Partnership will terminate if your partnership no longer meets the criteria described in the definition of “Domestic Partnership” in the DEFINITIONS SECTION of this Certificate. You are entitled to continue coverage for the same period of time as a spouse or child who loses coverage due to divorce.

[**Conversion Privilege**

Upon termination of your continuation coverage, you may exercise the privilege to become a member of Blue Cross and Blue Shield on a “direct pay” basis as specified in the Conversion Privilege of the ELIGIBILITY SECTION of this Certificate.]

HOW TO FILE A CLAIM

[Your benefits under this Certificate will be provided after Medicare has made its payment. Your Hospital and related Physician services Claims will be sent to Medicare for you. You must send your other medical Claims to Medicare first. Use a Medicare claim form (HCFA-1490s-SC). You can obtain this form from your local Social Security Administration office. You will receive a Medicare Summary Notice ("MSN") telling you what Medicare has paid on your Claim.]

New

Applicable to Medicare Supplement only

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

Revised

[If your Provider does not file your Claim, send Blue Cross and Blue Shield a copy of the MSN for your Claim. Be sure to print your Blue Cross and Blue Shield ID number at the top of the MSN. This number is on your Blue Cross and Blue Shield ID card. Mail your MSN to:

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

New

Applicable to Medicare Supplement only

Once Blue Cross and Blue Shield receives your Claim, it will be processed and the benefit payment will usually be sent directly to the Hospital or Physician. You will receive a statement telling you how much was paid. In some cases Blue Cross and Blue Shield will send the payment directly to you or if applicable, in the case of a Qualified Medical Child Support Order, to the designated representative as it appears on Blue Cross and Blue Shield's records.

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

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

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

Not applicable to Medicare Supplement

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

0.812a

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

0.812b

[In any case, Claims should be filed with Blue Cross and Blue Shield within 60 days of receiving your MSN from Medicare. If you are unable to file your Claim in 60 days, file it as soon as possible thereafter. Blue Cross and Blue Shield will process your Claim if you show it was not reasonably possible to file within 60 days and that you filed as soon as you reasonably could.]

New

0.812c
Applicable to Medicare Supplement only

Should you have any questions about filing Claims, ask your Group Administrator or call your local Blue Cross and Blue Shield office.]

Deleted obsolete subsections

[FILING OUTPATIENT PRESCRIPTION DRUG CLAIMS

Revised

In certain situations, you will have to file your own Claims in order to obtain benefits for Outpatient prescription drugs. 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 a prescription drug Claim Form. These forms are available from your Group Administrator or from your local Blue Cross and Blue Shield office.
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 14624
Lexington, KY 40512-4624]

Revised

[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.]

0.852a
Applicable to drug program only

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

New

0.852b
Applicable to fully integrated BlueSCRIPT

CLAIMS PROCEDURES

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

If the Claim is denied in whole or in part, you will receive a notice from Blue Cross and Blue Shield 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 Blue Cross and Blue Shield 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. Blue Cross and Blue Shield will review its decision in accordance with the following procedure.

Within 180 days after you receive notice of a denial or partial denial, write to Blue Cross and Blue Shield. Blue Cross and Blue Shield will need to know the reasons why you do not agree with the denial or partial denial. Send your request to:

[Claim Review Section
Blue Cross and Blue Shield of Illinois
P.O. Box 2401
Chicago, Illinois 60690-1364]

Revised

You may also designate a representative to act for you in the review procedure. 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.

[While Blue Cross and Blue Shield will honor telephone requests for information, such inquiries will not constitute a request for review.]

Not applicable to BlueChoice

You and your authorized representative may ask to see relevant documents and may submit written issues, comments and additional medical information within 180 days after you receive notice of a denial or partial denial. Blue Cross and Blue Shield will give you a written decision within[60][30] days after it receives your request for review.

[If you do not agree with the decision of Blue Cross and Blue Shield's review, you may request a second review. The request for a second review must be made within 30 days of receipt of the written decision from Blue Cross and Blue Shield. Blue Cross and Blue Shield will give you a written decision within 30 days after it receives your request for review.]

Applicable to BlueChoice only

If you have any questions about the Claims procedures or the review procedure, write or call Blue Cross and Blue Shield Headquarters. Blue Cross and Blue Shield offices are open from 8:45 A.M. to 4:45 P.M., Monday through Friday.

[Blue Cross and Blue Shield of Illinois
300 East Randolph
Chicago, Illinois 60601-5099]

Revised

If you have a Claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court.]

[FILING DENTAL CLAIMS

In order to obtain your dental benefits under this Certificate, it is necessary for a Claim to be filed with Blue Cross and Blue Shield.

To file a Claim, obtain an Attending Dentist's Statement from your Group Administrator before going to your Dentist. The Attending Dentist's Statement is also used for pre-estimation of benefits. It is your responsibility to insure that the necessary Claim information has been provided to Blue Cross and Blue Shield.

You must complete and sign the Subscriber/Insured Information of the Attending Dentist's Statement. As soon as treatment has ended, ask your Dentist to complete and sign the Attending Dentist's Statement, and file it with:

[Blue Cross and Blue Shield of Illinois
P.O. Box 23059
Belleville, Illinois 62223-0059]

Revised

[Claims must be filed with Blue Cross and Blue Shield on or before December 31st of the calendar year following the year in which your Covered Service was rendered. (A Covered Service furnished in the last month of a particular calendar year shall be considered to have been furnished in the succeeding calendar year.) Claims not filed within the required time period will not be eligible for payment. Should you have any questions about filing Claims, ask your Group Administrator or call your local Blue Cross and Blue Shield office.] 0.841a

[Claims must be filed no later than two years after the date a service is received. Claims not filed within two years from the date a service is received will not be eligible for payment. Should you have any questions about filing Claims, ask your Group Administrator or call your local Blue Cross and Blue Shield office.] 0.841b

[Claims must be filed with Blue Cross and Blue Shield within 365 days from the date your Covered Service was rendered. Claims not filed within the required time period will not be eligible for payment. Should you have any questions about filing Claims, ask your Group Administrator or call Blue Cross and Blue Shield.] 0.842b

DENTAL CLAIM PROCEDURES

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

If the Claim is denied in whole or in part, you will receive a notice from Blue Cross and Blue Shield with: (1) the reasons for denial; (2) a reference to the dental 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 Blue Cross and Blue Shield if you do not agree with the denial.

DENTAL CLAIM REVIEW PROCEDURES

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

Within 180 days after you receive notice of a denial or partial denial, write to Blue Cross and Blue Shield. Blue Cross and Blue Shield will need to know the reasons why you do not agree with the denial or partial denial. Send your request to:

[Blue Cross and Blue Shield of Illinois
P.O. Box 23059
Belleville, Illinois 62223-0059]

Revised

You may also designate a representative to act for you in the review procedure. 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.

While Blue Cross and Blue Shield will honor telephone requests for information, such inquiries will not constitute a request for review.

You and your authorized representative may ask to see relevant documents and may submit written issues, comments and additional medical information within 180 days after you receive notice of a denial or partial denial. Blue Cross and Blue Shield will give you a written decision within 60 days after it receives your request for review.

If you have any questions about the Claims procedures or the review procedure, write or call Blue Cross and Blue Shield Headquarters. Blue Cross and Blue Shield offices are open from 8:45 A.M. to 4:45 P.M., Monday through Friday.

[Blue Cross and Blue Shield of Illinois
300 East Randolph
Chicago, Illinois 60601-5099]

If you have a Claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court.]

GENERAL PROVISIONS

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

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

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

In the case of Hospitals and other facilities, the calculation of any out-of-pocket maximums or any maximum amounts of benefits payable by Blue Cross and Blue Shield under this Certificate and the calculation of all required deductible and Coinsurance amounts payable by you under this Certificate shall be based on the Eligible Charge or Provider's Claim Charge for Covered Services rendered to you, reduced by the Average Discount Percentage ("ADP") applicable to your Claim or Claims. Your Group has been advised that Blue Cross and Blue Shield may receive such payments, discounts and/or other allowances during the term of the Policy. Neither the Group nor you are entitled to receive any portion of any such payments, discounts and/or other allowances in excess of the ADP. 0.9

In the case of Physicians and Dentists, the calculation of any maximum amounts of benefits payable by Blue Cross and Blue Shield under this Certificate and the calculation of all required deductible and Coinsurance amounts payable by you under this Certificate shall be based on the lesser of the Usual and Customary FeeMaximum Allowance or Provider's Claim Charge for Covered Services rendered to you. Your Group has been advised that Blue Cross and Blue Shield may receive such payments, discounts and/or other allowances during the term of the Policy. Neither the Group nor you are entitled to receive any portion of any such payments, discounts and/or other allowances. 0.9

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

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

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

c. However, for purposes of calculating your deductible and Coinsurance amounts, and whether you have reached any out-of-pocket or benefit maximums, the Hospital's Eligible Charge would be reduced by the ADP applicable to your Claim. In our example, if the applicable ADP were 30%, the $1,000 Hospital bill would be reduced by 30% to $700 for purposes of calculating your deductible and Coinsurance amounts, and whether you have reached any out-of-pocket or benefit maximums.

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

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

So, in the example we are using, since the full Hospital bill is $1,000, your deductible has already been satisfied, and your Coinsurance is $140, then Blue Cross and Blue Shield has to satisfy the rest of the Hospital bill, or $860. Assuming Blue Cross and Blue Shield has a contract with the Hospital, Blue Cross and Blue Shield will usually be able to satisfy the $860 bill that remains after your Coinsurance and deductible, by paying less than $860 to the Hospital, often substantially less than $860. Blue Cross and Blue Shield receives, and keeps for its own account, the difference between the $860 bill and whatever Blue Cross and Blue Shield ultimately pays under its contracts with Plan Providers, and neither you nor your Group are entitled to any part of these savings.

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

Blue Card

Blue Cross and Blue Shield 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.

When you receive health care services through BlueCard outside of Illinois and from a Provider which does not have a contract with Blue Cross and Blue Shield, the amount you pay for Covered Services is calculated on the lower of: N/A to BlueCard POS

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

- The billed charges for your Covered Services, or

- The negotiated price that the Host Blue passes on to Blue Cross and Blue Shield.

To help you understand how this calculation would work, please consider the following example:

a. Suppose you receive covered medical services for an illness while you are on vacation outside of Illinois. You show your identification card to the provider to let him or her know that you are covered by Blue Cross and Blue Shield of Illinois.

b. The provider has negotiated with the Host Blue a price of $80, even though the provider's standard charge for this service is $100. In this example, the provider bills the Host Blue $100.

c. The Host Blue, in turn, forwards the claim to Blue Cross and Blue Shield of Illinois and indicates that the negotiated price for the covered service is $80. Blue Cross and Blue Shield of Illinois would then base the amount you must pay for the service – the amount applied to your deductible, if any, and your coinsurance percentage – on the $80 negotiated price, not the $100 billed charge.

d. So, for example, if your coinsurance is 20%, you would pay $16 (20% of $80), not $20 (20% of $100). You are not responsible for amounts over the negotiated price for a covered service.

PLEASE NOTE: The coinsurance percentage in the above example is for illustration purposes only. The example assumes that you have met your deductible and that there are no copayments associated with the service rendered. Your deductible(s), Coinsurance and Copayment(s) are specified in this Certificate.

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 or require a surcharge, Blue Cross and Blue Shield 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.

You will be entitled to benefits for health care services received by you either inside or outside the geographic area Blue Cross and Blue Shield serves, if those health care services are covered under this Certificate. Due to variations in Host Blue utilization management programs, you may receive benefits for some health care services obtained outside the geographic area Blue Cross and Blue Shield serves, even though you might not otherwise have received benefits if those health care services were rendered inside the geographic area Blue Cross and Blue Shield serves. But in no event will you be entitled to benefits for health care services, wherever you received them, that are specifically excluded or limited from coverage under this Certificate.]

applicable to BlueCard POS

[**Servicing Plans**

In some instances, Blue Cross and Blue Shield has entered into agreements with other Blue Cross and Blue Shield Plans ("Servicing Plans") to provide, on Blue Cross and Blue Shield's behalf, Claim Payments and certain administrative services for you. Under these agreements, Blue Cross and Blue Shield will reimburse each Servicing Plan for all Claim Payments made on Blue Cross and Blue Shield's behalf for you.

Certain Servicing Plans may have contracts similar to the contracts described above with certain Providers ("Servicing Plan Providers") in their service area. The Servicing Plan will process your claim in accordance with the Servicing Plan's applicable contract with the Servicing Plan Provider. Further, all amounts payable to the Servicing Plan by Blue Cross and Blue Shield for Claim Payments made by the Servicing Plan and applicable service charges, and all benefit maximum amounts and any required deductible and Coinsurance amounts under this Certificate will be calculated on the basis of the Servicing Plan Provider's Eligible Charge for Covered Services rendered to you or the cost agreed upon between the Servicing Plan and Blue Cross and Blue Shield for Covered Services that the Servicing Plan passes to Blue Cross and Blue Shield, whichever is lower.

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

In other instances, laws in a small number of states dictate the basis upon which the Coinsurance is calculated. When Covered Services are rendered in those states, the Coinsurance amount will be calculated using the state's statutory method.][

0.93

1. BLUE CROSS AND BLUE SHIELD'S SEPARATE FINANCIAL ARRANGEMENTS REGARDING PRESCRIPTION DRUGS]

Revised

[**Blue Cross and Blue Shield's Separate Financial Arrangements with Prescription Drug Providers**]

Blue Cross and Blue Shield 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 Blue Cross and Blue Shield is a party, including all persons covered under this Certif-

icate. Under its contracts with Participating Prescription Drug Providers, Blue Cross and Blue Shield 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.] 0.95

[Coinsurance amounts payable by you under this Certificate will be calculated on the basis of the provider's eligible charge or the agreed upon cost between the Participating Prescription Drug Provider and Blue Cross and Blue Shield for a prescription drug, whichever is lower.

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

a. Assume you have a prescription dispensed and the normal, full amount of the prescription drug is $100. How is the $100 bill paid?

b. You personally will have to pay the Coinsurance amount set out in this Certificate.

c. However, for purposes of calculating your Coinsurance amount, the full amount of the prescription drug would be reduced by the discount. In our example, if the applicable discount were 20%, the $100 prescription drug bill would be reduced by 20% to $80 for purposes of calculating your Coinsurance amount.

d. In our example, if your Coinsurance obligation is 25%, you personally will have to pay 25% of $80, or $20. You should note that your 25% Coinsurance is based upon the discounted amount of the prescription and not the full $100 bill.] 0.94

Blue Cross and Blue Shield's Separate Financial Arrangements with Pharmacy Benefit Managers

Blue Cross and Blue Shield owns a significant portion of the equity of Prime Therapeutics LLC and informs you that Blue Cross and Blue Shield has entered into one or more agreements with Prime Therapeutics LLC or other entities (collectively referred to as "Pharmacy Benefit Managers") to provide, on Blue Cross and Blue Shield's behalf, Claim Payments and certain administrative services for your prescription drug benefits. Pharmacy Benefit Managers have agreements with pharmaceutical manufacturers to receive rebates for using their products. The Pharmacy Benefit Manager may share a portion of those rebates with Blue Cross and Blue Shield. Neither the Group nor you are entitled to receive any portion of such rebates as they are figured into the pricing of the product.]

2. PAYMENT OF CLAIMS AND ASSIGNMENT OF BENEFITS

a. Under this Certificate, Blue Cross and Blue Shield has the right to make any benefit payment either to you or directly to the Provider of the Covered Services. For example, Blue Cross and Blue Shield may pay benefits to you if you receive Covered Services from a Non-Plan Provider. Blue Cross and Blue Shield is specifically authorized by you to determine to whom any benefit payment should be made.

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

c. A Covered Person's claim for benefits under this Certificate is expressly non-assignable and non-transferable in whole or in part to any person or entity, including any Provider, at anytime before or after Covered Services are rendered to a Covered Person. Coverage under this 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. Any such assignment or transfer of a claim for benefits or coverage shall be null and void.

3. YOUR PROVIDER RELATIONSHIPS

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

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

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

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

4. AGENCY RELATIONSHIPS

The Group is your agent under this Certificate. The Group is not the agent of Blue Cross and Blue Shield.

5. NOTICES

Any information or notice which you furnish to Blue Cross and Blue Shield under this Certificate must be in writing and sent to Blue Cross and Blue Shield at its offices at 300 East Randolph, Chicago, Illinois 60601-5099 (unless another address has been stated in this Certificate for a specific situation). Any information or notice which Blue Cross and Blue Shield furnishes to you must be in

writing and sent to you at your address as it appears on Blue Cross and Blue Shield'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 Blue Cross and Blue Shield's records.

6. LIMITATIONS OF ACTIONS

No legal action may be brought to recover under this Certificate, prior to the expiration of sixty (60) days after a Claim has been furnished to Blue Cross and Blue Shield in accordance with the requirements of this Certificate. In addition, no such action shall be brought after the expiration of three (3) years after the time a Claim is required to be furnished to Blue Cross and Blue Shield in accordance with the requirements of this Certificate.

7. INFORMATION AND RECORDS

You agree that it is your responsibility to ensure 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 indemnity on account of such illness or injury or on account of any previous illness or injury which may be pertinent to such Claim or Claims, furnish to Blue Cross and Blue Shield or its agent, and agree that any such Provider, person or other entity may furnish to Blue Cross and Blue Shield 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, Blue Cross and Blue Shield may furnish similar information and records (or copies of records) to Providers, 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 Blue Cross and Blue Shield and/or your employer or group administrator information regarding your or your dependents becoming eligible for Medicare, termination of Medicare eligibility or any change in Medicare eligibility status in order that Blue Cross and Blue Shield be able to make Claim Payments in accordance with MSP laws.][

8. VALUE BASED DESIGN PROGRAMS

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

Contact your employer for additional information regarding any value based programs offered by your employer. **New**

9. TIME LIMIT ON CERTAIN DEFENSES

After 2 years from the date of issue of this Certificate no misstatements, except fraudulent misstatements, made by the applicant in the application for such Cer-

tificate shall be used to void the Certificate or to deny a claim for illness or injury beginning after the expiration of such 2 year period.] 0.92

10. CONFORMITY WITH STATE STATUTES **Revised**

This Certificate provides, at a minimum, coverage as required by Illinois law. Laws in some other states require that certain benefits or provisions be provided to you if you are a resident of their state when the policy that insures you is not issued in your state. In the event any provision of this Certificate, on its effective date, conflicts with the laws of the state in which you permanently reside, you will be provided the greater of the benefit under this Certificate or that required under the laws of the state in which you permanently reside.

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 are provided for Covered Services described in this Certificate, you agree:

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

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

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

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

BlueCross BlueShield of Illinois

Experience. Wellness. Everywhere.℠

GB-10 HCSC

Effective Date:

www.bcbsil.com

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

GROUP CERTIFICATE RIDER

[(For [Community] Participating [Provider] [Select][Option] [Comprehensive Major Medical] Plans)]

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

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

A. EFFECTIVE DATE

[For Certificates in effect on or after September 23, 2010, this Rider is effective on the [Group effective date][agreement effective date][agreement date anniversary][contract date][or][plan year].]

[The effective date of this Rider is the first [Group effective date][agreement effective date][contract date][or][contract anniversary date][plan year] after September 23, 2010.]][

B. DEPENDENT COVERAGE

Benefits will be provided under this [health][dental] Certificate for your and/or your spouse's enrolled child(ren) under the age of [26-30].

no marital stat or stud stat

Child, used hereafter, means a natural child(ren), a stepchild(ren), [a child(ren) of your Domestic Partner,] an adopted child(ren) [(including a child(ren) who is in your custody under an interim court order of adoption or who is placed with you for adoption vesting temporary care),] [a [child(ren) of your child(ren),] [grandchild(ren),] [child(ren) for whom you are the legal guardian] under 26 years of age, regardless of presence or absence of a child(ren)'s financial dependency, residency, student status, employment status, marital status, [, eligibility for other coverage] or any combination of those factors. [If the covered child(ren) is eligible military personnel, the limiting age is 30 years of age as described under the **FAMILY COVERAGE** provision in the ELIGIBILITY SECTION of this Certificate.][For plan years beginning January 1, 2014, a child under 26 is not eligible for coverage if this coverage is a grandfathered health plan and the child is eligible to enroll in an eligible employer-sponsored health plan (as defined in Section 5000A(f)(2) of the Internal Revenue Code) other than a group health plan of a parent.]

For grandfathered plans

[In addition, benefits will be provided under this [health][dental] Certificate for your and/or your spouse's enrolled child(ren) who have reached the limiting age as specified above and who are unmarried and under age [27-30].]

For custom accounts w/marital stat; no stud stat

[In addition, benefits will be provided under this [health][dental] Certificate for your and/or your spouse's enrolled unmarried child(ren) who have reached the limiting age as specified above and who are full-time students under age [27-30].]][

For custom accounts w/marital stat & stud stat

C. PREEXISTING CONDITIONS WAITING PERIOD

The Preexisting Conditions waiting period will not apply to you and/or your enrolled family member(s) who are under age [19-30].][

D. EMERGENCY CARE SERVICES

For grandfathered plans

Notwithstanding anything in your Certificate to the contrary, for emergency care benefits rendered by [Non-Participating][Out-of-Network] Providers the [Eligible Charge][or][Maximum Allowance][Usual and Customary Fee] shall be equal to the greatest of the following amounts:

1. the amount negotiated with [Participating][In-Network] Providers for emergency care benefits furnished; or
2. the amount for the emergency care service calculated using the same method the [Participating][In-Network] Providers generally uses to determine payments for [Non-Participating][Out-of-Network] Provider services but substituting the [Participating][In-Network] cost sharing provisions for the [Non-Participating][Out-of-Network] Provider cost-sharing provisions; or
3. the amount that would be paid under Medicare for the emergency care service.

Each of these three amounts is calculated excluding any [Participating][In-Network] Provider [Copayment][or][Coinsurance] imposed with respect to the participant.]][

E. PREVENTIVE SERVICES

For ungrandfathered plans

The following provision is added to your Certificate:

PREVENTIVE SERVICES

Preventive care services will be provided for the following Covered Services and will not be subject to any [deductible,] Coinsurance, Copayment or dollar maximum[when such services are received [from a [Community or]Participating Provider][In-Network][from a Physician]]:

a. evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force ("USPSTF");
b. immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention ("CDC") with respect to the individual involved;
c. evidenced-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration ("HRSA") for infants, child(ren), and adolescents; and
d. with respect to women, such additional preventive care and screenings, not described in item a above, as provided for in comprehensive guidelines supported by the HRSA.

For purposes of this benefit, the current recommendations of the USPSTF regarding breast cancer screening and mammography and prevention will be

considered the most current (other than those issued in or around November 2009).

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

Examples of Covered Services included are routine physicals, immunizations, well child care, cancer screening mammograms, bone density tests, screenings for prostate cancer and colorectal cancer, smoking cessation counseling services, healthy diet counseling and obesity screening/counseling.

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

[If your plan covers Well Child Care and/or Wellness Care, Covered Services not included in items a. through d. above will be subject to [deductible,][Coinsurance,][Copayment] [and/or] [dollar maximum], if applicable.]

F. ANNUAL BENEFIT MAXIMUMS

[Any benefit period dollar maximum mentioned in this Certificate is deleted in its entirety.]

[The benefit period dollar maximum mentioned in this Certificate for the following Covered Service[s] [is][are] deleted and replaced with the following benefit period maximum[s]:[

- Coordinated Home Care—Your benefits for Coordinated Home Care will be limited to a maximum of [5-365] visits per benefit period.][
- Occupational Therapy—[Your benefits for Occupational Therapy will be limited to a maximum of [5-365] visits per benefit period.][Your benefits for Occupational Therapy, Physical Therapy and Speech Therapy are limited to a combined maximum of [20-365] visits per benefit period.]][
- Physical Therapy—[Your benefits for Physical Therapy will be limited to a maximum of [5-365] visits per benefit period.][Your benefits for Occupational Therapy, Physical Therapy and Speech Therapy are limited to a combined maximum of [20-365] visits per benefit period.]][
- Chiropractic and Osteopathic Manipulation—Your benefits for Chiropractic and Osteopathic Manipulation will be limited to a maximum of [5-365] visits per benefit period.][
- Speech Therapy—[Your benefits for Speech Therapy will be limited to a maximum of [5-365] visits per benefit period.][Your benefits for Occupational Therapy, Physical Therapy and Speech Therapy are limited to a combined maximum of [20-365] visits per benefit period.]][

- Private Duty Nursing Service—Your benefits for Private Duty Nursing Service will be limited to a maximum of [[5-365] days per benefit period][[1-30] days per month].][
- Skilled Nursing Facility—[Each time you are admitted to a Skilled Nursing Facility, you are entitled to benefits for [5-365] days of care.][You are entitled to benefits for [5-365] days of care in a Skilled Nursing Facility per benefit period.]][
- Additional bullets may be added to list removal of any client-specific annual benefit maximum previously approved by the [Name of Governing Body] under a single case filing.]][

[The benefit period maximum provision[s] mentioned in this Certificate for the following Covered Service[s] [is][are] deleted in their entirety:][For custom accounts

- Outpatient Substance Abuse Rehabilitation Treatment][
- Inpatient Substance Abuse Rehabilitation Treatment][
- Outpatient treatment of Mental Illness (other than Serious Mental Illness)][
- Inpatient treatment of Mental Illness (other than Serious Mental Illness)][
- Outpatient treatment of Serious Mental Illness][
- Inpatient treatment of Serious Mental Illness][
- Additional bullets may be added to list removal of any client-specific annual benefit maximum previously approved by the [Name of Governing Body] under a single case filing.]]][

G. LIFETIME MAXIMUMS

Any lifetime dollar maximum mentioned in this Certificate is deleted in its entirety.][

H. INTERNAL AND EXTERNAL REVIEW INFORMATION AND PROCEDURES

For ungrandfathered plans

The following provision is added to the HOW TO FILE A CLAIM section of your Certificate:

If a Claim Is Denied or Not Paid in Full

If the Claim is denied in whole or in part, within 30 days after Blue Cross and Blue Shield receives the Claim, you will receive a notice from Blue Cross and Blue Shield with:

1. The reasons for denial, including any denial codes and their corresponding meanings;
2. A reference to the Certificate provisions on which the denial is based;
3. A description of additional information which may be necessary to perfect an appeal;

4. Subject to privacy laws and other restrictions, if any, the identification of the Claim date of service, the health care provider, Claim amount, diagnosis codes and their corresponding meanings and the treatment codes and their corresponding meanings;
5. An explanation of Blue Cross and Blue Shield's internal review/appeals and external review processes (and how to initiate a review/appeal or external review);
6. An explanation of Blue Cross and Blue Shield's standard that was used in denying the Claim;
7. In certain situations, a statement in non-English language(s) that future notices of Claim denials may be available in such non-English language(s); and
8. Contact information for applicable office of health insurance consumer assistance or ombudsman.

For benefit determinations relating to urgent care, such notice will be provided no later than 24 hours after the receipt of your claim for benefits, unless you fail to provide sufficient information. You will be notified of the missing information and will have no less than 48 hours to provide the information. A benefit determination will be made within 48 hours after the missing information is received. For benefit determinations relating to care that is being received at the same time as the determination, such notice will be provided no later than 24 hours after receipt of your claim for benefits.

The following provisions replace any appeals procedures described throughout your Certificate:

CLAIM APPEAL PROCEDURES

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

An appeal may be filed by you, a person authorized to act on your behalf, or any health care provider. Your designation of a representative must be in writing as it is necessary to protect against disclosure of information about you except to your authorized representative. To obtain an Authorized Representative Form, you or your representative may call Blue Cross and Blue Shield at the number on the back of your ID card.

Within 180 days after you receive notice of a denial or partial denial, you may call or write to Blue Cross and Blue Shield to request a Claim review. Blue Cross and Blue Shield will need to know the reasons why you do not agree with

the denial or partial denial. You may call XXX-XXX-XXXX or send your request to:

[Name of Department]
[Name of Company]
[Address]
[Address]

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

Blue Cross and Blue Shield will provide you or your authorized representative with any new or additional evidence or rationale and any other information and documents used in the review of your Claim. The appeal will be conducted by individuals associated with Blue Cross and Blue Shield and/or by external advisors, but who were not involved in making the initial denial of your Claim.

Urgent/Expedited Clinical Appeals

If your situation meets the definition of an urgent/expedited clinical appeal, you may be entitled to an appeal on an expedited basis. An **urgent/expedited clinical appeal** is an appeal of a clinically urgent nature that relates to health care services, including, but not limited to, procedures or treatment ordered by a health care provider that, if a decision is denied, may significantly increase the risk to your life or health or your ability to retain maximum function may be in serious jeopardy or, in the opinion of your Physician, you may experience severe pain that cannot be adequately controlled while you wait for a decision on your appeal without the care or treatment that is the subject of the appeal. Claims for health care services that have already been provided do not meet the definition of urgent. Before authorization of benefits for an ongoing course of treatment is terminated or reduced, Blue Cross and Blue Shield will provide you with notice at least 24 hours before the previous benefits authorization ends and an opportunity to appeal. For the ongoing course of treatment, coverage will continue during the appeal process.

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

Non-Urgent/Expedited Clinical Appeals

Upon receipt of a non-urgent pre-service or post-service clinical appeal related to health care services, including, but not limited to, procedures or treatments ordered by a health care provider, Blue Cross and Blue Shield 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 days of the request. Blue Cross and Blue Shield shall render a determination on the appeal within 15 business days after it receives the requested information but in no event more than 30 days after the appeal has been received by Blue Cross and Blue Shield.

If You Need Assistance

If you have any questions about the Claims procedures or the review procedure, write or call Blue Cross and Blue Shield's Headquarters at XXX-XXX-XXXX. Blue Cross and Blue Shield offices are open from [Hours of Operations], [Days of Operations].

[Name of Company]
[Address]
[Address]

If you need assistance with the internal claims and appeals or the external review processes that are described below, you may contact the health insurance consumer assistance office or ombudsman. You may contact the Illinois ombudsman program at, XXX-XXX-XXXX or call the number on the back of your ID card for contact information. In addition, for questions about your appeal rights or for assistance, you can contact the Employee Benefits Security Administration at XXX-XXX-XXXX.

Notice of Clinical Appeal Determination

Blue Cross and Blue Shield will notify the party filing the appeal, you, 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 notice will include:

- A reason for the determination.
- Medical or clinical criteria used in the determination.
- Procedures for requesting an independent external review, if your appeal is denied.

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

If an appeal is not resolved to your satisfaction, you may appeal Blue Cross and Blue Shield's decision to the [Name of Governing Body]. The [Name of Governing Body] will notify Blue Cross and Blue Shield of the appeal. Blue Cross and Blue Shield will have 21 days to respond to the [Name of Governing Body].

If you have a Claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court.

INDEPENDENT EXTERNAL REVIEW

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

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

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

1. **Standard External Review**

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

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

      - You were a covered person at the time health care service was requested or provided;
      - The service that is the subject of the Adverse Determination or the Final Adverse Determination is a Covered Service under this Certificate, but Blue Cross and Blue Shield has determined that the health care service does not meet Blue Cross and Blue Shield's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness;
      - You have exhausted Blue Cross and Blue Shield's internal grievance process; and
      - You have provided all the information and forms required to process an external review.

      For appeals relating to a determination based on treatment being experimental or investigational, Blue Cross and Blue Shield will complete a preliminary review to determine whether the requested service or treatment that is the subject of the Adverse Determination or Final Adverse Determination is a Covered Service, except for Blue Cross and Blue Shield's determination that the service or treatment is

experimental or investigational for a particular medical condition and is not explicitly listed as an excluded benefit. In addition, the Physician who ordered or provided the services in question has certified that one of the following situations is applicable:

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

b. Notification. Within one business day after completion of the preliminary review, Blue Cross and Blue Shield shall notify you and your authorized representative, if applicable, in writing whether the request is complete and eligible for an external review. If the request is not complete or not eligible for an external review, you shall be notified by Blue Cross and Blue Shield in writing of what materials are required to make the request complete or the reason for its ineligibility.

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

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

d. **IRO's Decision.** Within five days after the date of receipt of the necessary information, the external independent reviewer will render its decision to uphold or reverse the Adverse Determination or Final Adverse Determination. You and your authorized representative, if applicable, will receive written notice from Blue Cross and Blue Shield. Until July 1, 2013, if you disagree with the determination of the external independent reviewer, you may appeal the decision of the external independent review organization to the [Name of Governing Body] at XXX–XXX–XXXX.

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

2. **Expedited External Review**

   If you have a medical condition where the timeframe for completion of (a) an expedited internal review of a grievance involving an Adverse Determination; (b) a Final Adverse Determination as set forth in the Illinois Managed Care Reform and Patient Rights Act; or, (c) a standard external review as set forth in the Illinois Health Care External Review Act, would seriously jeopardize your life or health or your ability to regain maximum function, then you have the right to have the Adverse Determination or Final Adverse Determination reviewed by an IRO not associated with Blue Cross and Blue Shield. In addition, if a Final Adverse Determination concerns an admission, availability of care, continued stay or health care service for which you received emergency services, but have not been discharged from a facility, then you may request an expedited external review.

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

   Your request for an expedited independent external review may be submitted orally or in writing. Upon receipt of your request, an independent review organization registered with the [Name of Governing Body] will be assigned to review Blue Cross and Blue Shield's decision.

   Within 48 hours after the date of receipt of all necessary information, the expedited independent external reviewer will render a decision whether or not to uphold or reverse the Adverse Determination or Final Adverse Determination and you will receive notification from Blue Cross and Blue Shield. Until July 1, 2013, if you disagree with the determination of the

external independent reviewer, you may contact the [Name of Governing Body].

NON-CLINICAL APPEALS

A non-clinical appeal is an appeal of non-clinical issues, such as appeals pertaining to administrative procedures.

Upon receipt of a pre-service or post-service non-clinical appeal, Blue Cross and Blue Shield 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 days of the request. Blue Cross and Blue Shield shall render a decision on the appeal within 15 business days after it receives the requested information.

Notice of Non-Clinical Appeals Determination

Blue Cross and Blue Shield 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 notice 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 [Name of Governing Body] or keep the [Name of Governing Body]from investigating a complaint. You can contact the [Name of Governing Body] at the following addresses:

[Name of Governing Body]

[Address of Governing Body]

or

[Name of Governing Body]
[Address of Governing Body]

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

I. GRANDFATHERED HEALTH PLAN DISCLOSURE

This group health plan believes this coverage is a “grandfathered health plan” under the Affordable Care Act. As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that the policy may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing.

However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime dollar limits on benefits for any individual.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to your Employer or the plan administrator.

If your group health plan is subject to the Employee Retirement Income Security Act (ERISA), you may also contact the Employee Benefits Security Administration, U.S. Department of Labor at X-XXX-XXX-XXXX or www.dol.gov/ebsa/healthreform. This Web site has a table summarizing which protections do and do not apply to grandfathered health plans. For non-federal governmental plans, inquiries may be directed to the U.S. Department of Health and Human Services at www.healthreform.gov.]

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

Attest:

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

[Signature]
[President's Name]
President

[Signature]
[Secretary's Name]
Secretary

State: Arkansas **Filing Company:** Health Care Service Corporation
TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.001A Any Size Group - PPO
Product Name: HCSC ET BCBS AR-IL
Project Name/Number: HCSC ET BCBS AR-IL/HCSC ET BCBS AR-IL

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Approved-Closed	08/08/2012
Comments:			
Attachment(s):			
Readability BCBSIL and AR ET.pdf			

		Item Status:	Status Date:
Satisfied - Item:	Application	Approved-Closed	08/08/2012
Comments:			
Attachment(s):			
IL Enrollment Form.pdf			

		Item Status:	Status Date:
Bypassed - Item:	PPACA Uniform Compliance Summary	Approved-Closed	08/08/2012
Bypass Reason:	no PPACA summary filed with the Illinois documents, not required it at the time the riders were filed.		
Comments:			

		Item Status:	Status Date:
Satisfied - Item:	Authorization	Approved-Closed	08/08/2012
Comments:			
Attachment(s):			
HCSC Authorization to File.pdf			

		Item Status:	Status Date:
Satisfied - Item:	AR_AR Certif of Compliance with Rule 19	Approved-Closed	08/08/2012
Comments:			
Attachment(s):			
AR_AR Certif of Compliance with Rule 19.pdf			

State: Arkansas **Filing Company:** Health Care Service Corporation
TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.001A Any Size Group - PPO
Product Name: HCSC ET BCBS AR-IL
Project Name/Number: HCSC ET BCBS AR-IL/HCSC ET BCBS AR-IL

		Item Status:	Status Date:
Satisfied - Item:	AR BCBSIL Certification of Benefit Differential	Approved-Closed	08/08/2012
Comments:			
Attachment(s):			
AR BCBSIL Certification of Benefit Differential.pdf			

		Item Status:	Status Date:
Satisfied - Item:	Cover Letter	Approved-Closed	08/08/2012
Comments:			
Attachment(s):			
AR - IL Cover LEtter.pdf			

Health Care Service Corporation
300 E. Randolph Street
Chicago, IL 60601

READABILITY CERTIFICATION

To the best of our knowledge and ability we have determined the Flesch scale analysis readability test scores to be as shown:

Form Number	Flesch Score
GB-10-1 HCSC	41.0
ETGB-AR-HCSC – 2012	40.0
GB-10-A 184 HCSC	40.9

By:_____
Scott Hilgeman

Title: Vice President and Chief Underwriter

GROUP ENROLLMENT APPLICATION/CHANGE FORM

For

Health Care Service Corporation Employees enrolled in any health plan available in their area

(excluding HMO Illinois and BlueAdvantage℠ HMO)

PLEASE READ THOROUGHLY THE INFORMATION IN EACH SECTION BEFORE COMPLETING THIS APPLICATION/CHANGE FORM

BlueCross BlueShield

Experience. Wellness. Everywhere.®

20748.1010

Group # | Section # | Dept #

ENROLLMENT APPLICATION/ CHANGE FORM

(excluding HMO Illinois and BlueAdvantage HMO)

BlueCross BlueShield
Experience. Wellness. Everywhere.®

SECTION 1 — ENROLLMENT EVENTS

PLEASE CHECK ALL THAT APPLY

☐ New Enrollment* ☐ Add Dependent ☐ Cancel Dependent ☐ Waive Coverage (refer to section 7)

SECTION 2 — PLEASE TELL US ABOUT YOURSELF

Last Name	First	Middle	Sex ☐ Male ☐ Female	Social Security Number ___-__-____

Birth Date (Mo Day Yr)	Employment Date (Mo Day Yr)	Name of Employer HCSC	Cost Center	Payroll Number	Work Phone No. ( )

Home Address — No. and Street Address	City	State	Zip	Home Phone No. ( )

SECTION 3 — SELECT YOUR COVERAGE

Medical (select one)

☐ PPO
☐ BlueEdge HCA
☐ BlueEdge HSA
☐ BLUE CHOICE SELECT (IL Only)
☐ HMO (TX, NM, OK Only)
☐ Waive Coverage (refer to section 7)

*new enrollees must make a selection

New Enrollees (select one)

☐ Employee Only
☐ Employee/Spouse
☐ Employee/Children
☐ Family
☐ Employee/Domestic Partner
☐ Employee/Domestic Partner/ Domestic Partner's Child

Dental

☐ Basic PPO
☐ Enhanced PPO
☐ DHMO (IL Only)
☐ Family
☐ Employee Only
☐ Employee/Spouse
☐ Employee/Children
☐ Employee/ Domestic Partner
☐ Employee/ Domestic Partner/ Domestic Partner's Child

SECTION 4 — APPLYING FOR HEALTH COVERAGE

SELECT A PCP FOR HMO.

☐ Add ☐ Drop	**Employee/Enrollee's Name**	Applicant's PCP Name	PCP No.	New Patient? ☐ Y ☐ N
☐ Add ☐ Drop	**Dependent's Name** ☐ Husband ☐ Wife ☐ Domestic Partner ☐ Common Law Spouse	Dependent's PCP Name	PCP No.	New Patient? ☐ Y ☐ N
	Dependent's Social Security No. ___-__-____	DOB (Mo Day Yr)	Home Address, if different — No. and Street Name City State Zip	
☐ Add ☐ Drop	**Dependent's Name** ☐ Son ☐ Daughter ☐ Dependent of Dependent Child (parent's name_____) ☐ Domestic Partner's Child	Dependent's PCP Name	PCP No.	New Patient? ☐ Y ☐ N
	Dependent's Social Security No. ___-__-____	DOB (Mo Day Yr)	Home Address, if different — No. and Street Name City State Zip	
☐ Add ☐ Drop	**Dependent's Name** ☐ Son ☐ Daughter ☐ Dependent of Dependent Child (parent's name_____) ☐ Domestic Partner's Child	Dependent's PCP Name	PCP No.	New Patient? ☐ Y ☐ N
	Dependent's Social Security No. ___-__-____	DOB (Mo Day Yr)	Home Address, if different — No. and Street Name City State Zip	
☐ Add ☐ Drop	**Dependent's Name** ☐ Son ☐ Daughter ☐ Dependent of Dependent Child (parent's name_____) ☐ Domestic Partner's Child	Dependent's PCP Name	PCP No.	New Patient? ☐ Y ☐ N
	Dependent's Social Security No. ___-__-____	DOB (Mo Day Yr)	Home Address, if different — No. and Street Name City State Zip	

Important Notice — Eligible Children

Eligible children include:

- Your children who are under the age of 26.
- Your child of any age who is physically or mentally disabled and unable to earn a living, provided they were covered prior to reaching the limiting age of 26.
- Grandchildren may be eligible for coverage if they are under your legal guardianship and a court order (signed by a judge) is provided.
- Grandchildren who meet the "Dependent of Dependent Children" provision. For your grandchild to be eligible as a dependent child of your dependent, your child must be covered under the plan, your grandchild must be a member of your household, your home must be their principal place of residence and you must furnish over half of his/her support for the year. The grandchild must be claimed on your tax return, a tax affidavit is completed, a copy of the birth certificate is provided.

(The "Dependent of Dependent Children" provision does not apply to Domestic Partners.)

Note: "Children" includes natural and legally adopted children, step-children and children under your legal guardianship. You may cover your children regardless of marital or support status up to the age of 26. However, if your child has access to group health and dental coverage through his or her own employer or the spouse's employer, he or she is not eligible.

SECTION 5 — OTHER COVERAGE INFORMATION

Are you or any member of your family listed above covered by any other health or dental coverage? ☐ Yes ☐ No List names of every individual covered:

Type of Coverage ☐ Health ☐ Dental	Group Coverage ☐ Yes ☐ No	Name and Address of Other Health Care Company

Name of Policyholder	Birth Date (Mo Day Yr)	☐ Male ☐ Female	Relationship to Applicant ☐ Self ☐ Spouse ☐ Dependent	Type of Coverage ☐ Self ☐ Two Person ☐ Family

ID Number	Employment Date	Effective Date of Coverage	Group or Policy Number	Employer's Name

SECTION 6 — MEDICARE COVERAGE INFORMATION

Name of person covered:	☐ Medicare A (Hospital) Effective Date: ___/___/___ ☐ Medicare B (Medical) Effective Date: ___/___/___	Medicare No. (From Medicare Card)
Name of person covered:	☐ Medicare A (Hospital) Effective Date: ___/___/___ ☐ Medicare B (Medical) Effective Date: ___/___/___	Medicare No. (From Medicare Card)

Please check the reason for Medicare Eligibility ☐ Entitled Age ☐ Entitled Disability ☐ End-Stage Renal Disease ☐ Disability and Current Renal Disease

SECTION 7 — WAIVE HEALTH COVERAGE

This is to certify the available coverage has been explained to me. I have been given the opportunity to apply for the coverage offered to me and my eligible dependents and have voluntarily elected to waive the coverage as indicated below. If I desire to apply for coverage at a later date, I understand there may be a delay in the effective date of the coverage.

Name ☐ Employee	Reason for waiving:	☐ Other Group Coverage	☐ Medicare	☐ Medicaid	☐ Other, explain:
Name ☐ Spouse	Reason for waiving:	☐ Other Group Coverage	☐ Medicare	☐ Medicaid	☐ Other, explain:
Name ☐ Child	Reason for waiving:	☐ Other Group Coverage	☐ Medicare	☐ Medicaid	☐ Other, explain:
Name ☐ Child	Reason for waiving:	☐ Other Group Coverage	☐ Medicare	☐ Medicaid	☐ Other, explain:
Name ☐ Child	Reason for waiving:	☐ Other Group Coverage	☐ Medicare	☐ Medicaid	☐ Other, explain:

IMPORTANT NOTICE — WAIVE HEALTH COVERAGE

If you are waiving enrollment for yourself or your dependents (including your spouse) because of other health care coverage, you may in the future be able to enroll yourself or your dependents in the plan, provided you request enrollment within 31 days after your other coverage ends. In addition, if you have a new dependent as a result of a marriage, birth, or adoption or becoming a party in a suit for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 31 days after marriage, birth, adoption or suit for adoption.

SECTION 8 — TOBACCO USAGE CERTIFICATION for Health Coverage

A Tobacco User is defined as a person who has smoked or used any tobacco products, such as cigarettes, cigars or smokeless tobacco products (including but not limited to electronic or e-cigarettes), within the 90 days immediately prior to the date of this application. If you or any of your covered dependents have used tobacco products during such 90-day period, you may still check the "No" box below, but only if it is unreasonably difficult due to a medical condition for you (or your dependents) to stop using tobacco products (or if it is medically inadvisable for you to attempt to stop), the surcharge can be avoided by submitting documentation from your doctor. The documentation must state that you and/or your dependent cannot quit the use of tobacco products due to a medical condition or it is medically inadvisable to stop.

I hereby certify that:

☐ Yes, I or one of the dependents enrolled on my health coverage meet the definition of a Tobacco User.

☐ No, neither I nor any of the dependents enrolled on my health coverage meet the definition of a Tobacco User.

☐ Due to a qualifying event such as divorce or loss of dependent eligibility, the only person enrolled on my health coverage who met the definition of a Tobacco User is being dropped from my coverage.

SECTION 9 — COVERAGE CONDITIONS

- I am an employee of the Employer named in this Application. I am eligible to participate in the coverage(s) afforded by my Plan, which is either underwritten or administered by HCSC. On behalf of myself and any dependents listed on the Application, I apply for those coverage(s) for which I am eligible. I state that the information given on my Application is true and correct. I understand and agree that any incorrect statements material to the risk and knowingly made by me will invalidate my coverage(s).
- Only those coverage(s) and amounts for which I am eligible will be available to me. I understand that if this Application is accepted, the coverage(s) will become effective in accordance with the provisions of the Contract(s).
- I authorize necessary payroll deduction by my Employer, if any, to cover the cost of my coverage(s). I agree that my Employer acts as my agent. All notices given to my Employer are binding upon me. I also agree that my participation in the coverage(s) is subject to any future amendments.
- I authorize any hospital, physician, dentist, provider, insurance carrier, or other entity, upon request, to provide HCSC any information covering the health condition of any person included under my coverage(s) whenever the information is considered necessary by the Companies for proper disposition of this Application/Change form or of a claim submitted.
- I understand that waiving health coverage for myself is only an option if I have other coverage and if I am waiving coverage for myself, in doing so I am affirming that I have other medical coverage.

Applicant's Signature_____ Date_____

Sworn Statement Regarding Qualifying Change in Family Status Allowed Under Section 125 of the Internal Revenue Code

You cannot add or drop dependents except during Open Enrollment or unless you have a "Qualifying Change in Family Status ". Any such change must be reported to HR Employee Services on the Enrollment/Change Form within 31 days of the qualifying change in family status.* Please indicate below the "Qualifying Change in Family Status" which necessitates the change in dependent coverage:

My signature on this page certifies that the information I have given below is true and correct.

(1) List the name and birth date of all affected dependents on the Enrollment/Change Form.

(2) Please include the Social Security Number for all dependents being added to coverage on the Change Form.

(3) Date of Event (of gain or loss of coverage) _____
Month / Day / Year

(4) **Specify Applicable Qualifying Change in Family Status:**

❏ Marriage (Employee got married) ❏ Divorce ❏ Adoption

❏ Married another HCSC employee Name: _____ID#_____

Child loss/gained coverage, complete information below:

❏ Marriage (Child got married) ❏ Child Attaining Age 26

❏ Child no longer meets HCSC definition of "dependent"

❏ Child ____Lost ____ Gained coverage elsewhere, complete information below:

Insurance Co:_____ Policyholder: _____

(To add a newborn, call Employee Services – 1-866-977-7378 – within 31 days of date of birth)
Spouse or Domestic partner loss or gained coverage, complete information below:

❏ Change in spouse or domestic partner's employment resulting in **loss** of coverage.

❏ Change in spouse or domestic partner's employment resulting in **gaining** coverage.

Name of spouse or domestic partner: _____

Spouse or domestic partner's employer: _____

Spouse or domestic partner's insurance carrier: _____

(5) Other Qualifying Event not listed (please specify) _____

_____

Emp ID#: _____ Emp Work Phone#: (___) _____

Date: _____ Employee Signature: _____

**Additional documentation may be requested.*

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

BlueCross BlueShield of Illinois

NAIC Company Code: 70670

Re: Group Medical Forms

To: All State Insurance Departments

Health Care Service Corporation, a Mutual Legal Reserve Company, which also does business as Blue Cross and Blue Shield of Illinois, Blue Cross Blue Shield of Texas, Blue Cross Blue Shield of Oklahoma and Blue Cross Blue Shield of New Mexico**,** hereby authorizes Compliance Research Services, LLC to represent us in the submission of the above-referenced forms and to negotiate with insurance departments for their approval.

Sincerely,

Health Care Service Corporation,
a Mutual Legal Reserve Company

Karen M. Atwood

Karen M. Atwood
Senior Vice President
National Accounts

Insurer: Health Care Service Corporation, a Mutual Legal Reserve Company

Form Number(s): GB-10-1 HCSC
ETGB-AR-HCSC-2011

I hereby certify that the filing above meets all applicable Arkansas requirements including the requirements of Rule and Regulation 19.

Signature of Company Officer

Scott Hilgeman

Name

Vice President and Chief Underwriter

Title

February 3, 2011
Date

STATE OF ARKANSAS

CERTIFICATION OF COMPLIANCE

Company Name: Health Care Service Corporation

Form Numbers: GB-10-1 HCSC and ETGB-AR-HCSC-2012

I hereby certify that to the best of my knowledge and belief, the above forms and submission comply with Arkansas Insurance Bulletin 9-85, in that the differential of benefits between PPO and non-PPO providers does not exceed 25%.

Scott Hilgeman
Vice President and Chief Underwriter

January 30, 2012
Date

10921 Reed-Hartman Highway, Suite 334
Cincinnati, Ohio 45242
(Tel) 513.984.6050
(Fax) 513.984.7212
(E-mail) dsimon@crssolutionsgroup.com

August 6, 2012

Arkansas Insurance Department
1200 West Third Street
Little Rock, AR 72201-1904

Re: Health Care Service Corporation, a Mutual Legal Reserve Company
NAIC# 70670-0917
FEIN# 36-1236610
Out-of-state Group Major Medical Forms
Form Number(s): (See attached list of forms)

Dear Commissioner:

Compliance Research Services is pleased to submit the enclosed forms on behalf of Health Care Service Corporation, a Mutual Legal Reserve Company (HCSC). A letter of filing authorization is enclosed.

HCSC does business in various states as follows:

- Blue Cross and Blue Shield of Illinois in Illinois;
- Blue Cross and Blue Shield of Texas in Texas;
- Blue Cross and Blue Shield of Oklahoma in Oklahoma; and
- Blue Cross and Blue Shield of New Mexico in New Mexico.

This filing is for HCSC's Illinois division however, we will be submitting similar filings for the other divisions of the company. Certificates delivered to employees resident in Arkansas are issued pursuant to out-of-state group policies issued in Illinois.

The purpose of this filing is to update a previous version of an Arkansas Extraterritorial Benefits Rider with current Arkansas mandated. The previous version of this rider was approved by your Department on June 3, 2008, Form ETGB-AR-HCSC-07, under SERFF Tracking Number: CMPL-125619854.

The Arkansas Rider will be used with the enclosed Illinois Certificate, form GB-10-1 HCSC.

Submitted Materials. The coverage in question is true group coverage sold in Illinois by licensed Illinois agents and brokers.

The provisions of the certificate may change according to the benefits negotiated between the employer and HCSC. The enclosed certificate includes provisions for participating provider hospitals and physicians. Coverage may also be issued on a fee for service basis without the network provisions. Individuals insured under network plans have access to their local Blue Cross provider networks under the national Blue Cross Association BlueCard plan.

Enclosed also is rider form GB-10-A184 HCSC, showing proof of compliance with PPACA. This rider was approved by the policy situs state of Illinois on March 26, 2011.

Provisions in the certificate that may vary from employer to employer are bracketed. HCSC requests the right to change the type style and paper size or to issue the forms in electronic format.

The forms have been tested for readability. Certification of readability is enclosed.

If you have any questions or comments, please call me at 513-894-6050 or by email at dsimon@crssolutionsgroup.com.

Thank you for your assistance in this matter.

Sincerely,

J. David Simon, CLU
President
Phone: 513.984.6050
Fax: 513.984.7212
E-Mail Address: dsimon@crssolutionsgroup.com

FORMS LISTING

FORM NUMBER:	DESCRIPTION:
ETGB-AR-HCSC-2012	Arkansas Extraterritorial Benefits Rider
GB-10-1 HCSC	Certificate – BCBS of Illinois
GB-10-A184 HCSC	Group Certificate Rider/PPACA and other