CONTRACT NO. 11-87-011 A

PROFESSIONAL SERVICES AGREEMENT

EMPLOYER-SPONSORED HEALTH INSURANCE BENEFITS

AND RELATED SERVICES

BETWEEN

COOK COUNTY GOVERNMENT
RISK MANAGEMENT

AND

BLUE CROSS AND BLUE SHIELD OF ILLINOIS, A DIVISION OF HEALTH CARE SERVICE CORPORATION, A MUTUAL LEGAL RESERVE COMPANY

APPROVED BY BOARD OF
COOK COUNTY COMMISSIONERS

JAN 1 8 2012

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PROFESSIONAL SERVICES AGREEMENT

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AGREEMENT

This Agreement, dated as of December 1, 2011, is made and entered into by and between the County of Cook, a body politic and corporate of the State of Illinois, on behalf of Office of the Purchasing Agent hereinafter referred as "County" and Blue Cross Blue Shield of Illinois a Division of Health Care Service Corporation a Mutual Legal Reserve Company, doing business as a corporation of the State of Illinois hereinafter referred to as "Vendor", pursuant to authorization by the Cook County Board of Commissioners on the 7th day of September, 2011, as evidenced by Board Authorization letter attached hereto as Exhibit "4".

BACKGROUND

The County of Cook issued a Request for Proposals "RFP" for Employer-Sponsored Health Insurance Benefits. Proposals were evaluated in accordance with the evaluation criteria published in the RFP. The Vendor was selected based on the proposal submitted and evaluated by the County representatives.

Vendor represents that it has the professional experience and expertise to provide the necessary services and further agrees that it is ready, willing and able to perform in accordance with the terms and conditions as set forth in this Agreement.

NOW, THEREFORE, the County and Vendor agree as follows:

TERMS AND CONDITIONS

ARTICLE 1) INCORPORATION OF BACKGROUND

The Background information set forth above is incorporated by reference as if fully set forth here.

ARTICLE 2) DEFINITIONS

a) Definitions

The following words and phrases have the following meanings for purposes of this Agreement:

"**Additional Services**" means those services which are within the general scope of Services of this Agreement, but beyond the description of services required under Article 3, and all services reasonably necessary to complete the Additional Services to the standards of performance required by this Agreement. Any Additional Services requested by the Department or proposed by the Vendor must be reviewed and approved by the Department and requires the approval of the CPO in a written modification to this Agreement before Vendor is obligated to perform

those Additional Services and before the County becomes obligated to pay for those Additional Services.

"**Agreement**" means this Agreement, including all exhibits attached to it and incorporated in it by reference, and all amendments, modifications or revisions made in accordance with its terms.

"**Chief Procurement Officer" or "CPO"** means the Chief Procurement Officer for the County of Cook and any representative duly authorized in writing to act on his behalf.

"**Department**" means the Cook County Department of Risk Management.

"**Services**" means, collectively, the services, duties and responsibilities described in Article 3 of this Agreement and any and all work necessary to complete them or carry them out fully and to the standard of performance required in this Agreement.

"**Subcontractor**" means any person or entity with whom Vendor contracts solely to provide Services under this Agreement to provide any part of the Services.

b) Interpretation

i) The term "**include**" (in all its forms) means "include, without limitation" unless the context clearly states otherwise.

ii) All references in this Agreement to Articles, Sections or Exhibits, unless otherwise expressed or indicated are to the Articles, Sections or Exhibits of this Agreement.

iii) Words importing persons include firms, associations, partnerships, trusts, corporations and other legal entities, including public bodies, as well as natural persons.

iv) Any headings preceding the text of the Articles and Sections of this Agreement, and any table of contents or marginal notes appended to it, are solely for convenience or reference and do not constitute a part of this Agreement, nor do they affect the meaning, construction or effect of this Agreement.

v) Words importing the singular include the plural and vice versa. Words of the masculine gender include the correlative words of the feminine and neuter genders.

vi) All references to a number of days mean calendar days, unless expressly indicated otherwise.

c) Incorporation of Exhibits

The following attached Exhibits are made a part of this Agreement:

Exhibit 1	Scope of Services
Exhibit 2	Schedule of Compensation
Exhibit 3	Evidence of Insurance
Exhibit 4	Board Authorization

ARTICLE 3) DUTIES AND RESPONSIBILITIES OF VENDOR

a) Scope of Services

This description of Services is intended to be general in nature and is neither a complete description of Vendor's Services nor a limitation on the Services that Vendor is to provide under this Agreement. Vendor must provide the Services in accordance with the standards of performance set forth in Section 3c. The Services that Vendor must provide include, but are not limited to, those described in Exhibit 1, Scope of Services and Time Limits for Performance, which is attached to this Agreement and incorporated by reference as if fully set forth here.

b) Deliverables

In carrying out its Services, Vendor must prepare or provide to the County various Deliverables. **"Deliverables"** include work product, such as written reviews, recommendations, reports and analyses, produced by Vendor for the County.

The County may reject Deliverables that do not include relevant information or data, or do not include all documents or other materials specified in this Agreement or reasonably necessary for the purpose for which the County made this Agreement or for which the County intends to use the Deliverables in accordance with this Agreement.

Partial or incomplete Deliverables may be accepted for review only when required for a specific and well-defined purpose and when consented to in advance by the County. Such Deliverables

will not be considered as satisfying the requirements of this Agreement and partial or incomplete Deliverables in no way relieve Vendor of its commitments under this Agreement.

c) Standard of Performance

Vendor must perform all Services required of it under this Agreement at a level not less than the service levels described in Vendor's proposal, an excerpt of which is appended hereto as Attachment 2. Vendor acknowledges that it is entrusted with or has access to valuable and confidential information and records of the County.

Vendor must assure that all Services that require the exercise of professional skills or judgment

are accomplished by professionals qualified and competent in the applicable discipline and appropriately licensed, if required by law. Consultant must provide copies of any such licenses.

d) Personnel

i) Adequate Staffing

Vendor must, upon receiving a fully executed copy of this Agreement, assign and maintain during the term of this Agreement and any extension of it an adequate staff of competent personnel that is fully equipped, licensed as appropriate, available as needed, qualified and assigned to perform the Services. Vendor must include among its staff the Key Personnel and positions as identified below. The level of staffing may be revised from time to time by

ii) Key Personnel

Vendor must not reassign or replace Key Personnel without the consent of the County, which consent the County will not unreasonably withhold. "Key Personnel" means those job titles and the persons assigned to those positions in accordance with the provisions of this Section 3.d(ii). The Department may at any time in writing notify Vendor that the County will no longer accept performance of Services under this Agreement by one or more Key Personnel listed. Upon that notice Vendor must immediately suspend the services of the key person or persons and must replace him or them in accordance with the terms of this Agreement.
List of Key Personnel:

Name:	Title:
Sandra Gonzalez	Principal Account Executive

e) Minority and Women's Business Enterprises Commitment

In the performance of this Agreement, including the procurement and lease of materials or equipment, Vendor must abide by the minority and women's business enterprise commitment requirements of the Cook County Ordinance, (Article IV, Section 34-277) except to the extent waived by the Compliance Director. Vendor's completed MBE/WBE Utilization Plan evidencing its compliance with this requirement are a part of this Agreement, in as set forth in the Economic Disclosure Statement upon acceptance by the Compliance Director. Vendor must utilize minority and women's business enterprises at the greater of the amounts committed to by the Vendor for this Agreement .

f) Insurance

Vendor must provide and maintain at Vendor's own expense, during the term of this Agreement and any time period following expiration if Vendor is required to return and

perform any of the Services or Additional Services under this Agreement, the insurance coverages and requirements specified below, insuring all operations related to this Agreement.

i) **Insurance To Be Provided**

(1) Workers Compensation and Employers Liability

Workers Compensation Insurance, as prescribed by applicable law, covering all employees who are to provide a service under this Agreement and Employers Liability coverage with limits of not less than $500,000 each accident or illness.

(2) Commercial General Liability (Primary and Umbrella)

Commercial General Liability Insurance or equivalent with limits of not less than $2,000,000 per occurrence for bodily injury, personal injury and property damage liability. Coverages must include the following: All premises and operations, products/completed operations, severability of interests defense and contractual liability. Cook County is to be named as an additional insured on a primary, non-contributory basis.

(3) Automobile Liability (Primary and Umbrella)

When any motor vehicles (owned, non-owned and hired) are used in connection with Services to be performed, Vendor must provide Automobile Liability Insurance with limits of not less than $1,000,000 per occurrence limit, for bodily injury and property damage. The County is to be named as an additional insured on a primary, non-contributory basis.

(4) Errors & Omissions-Professional Liability

Professional Liability Insurance covering acts, errors or omissions must be maintained with limits of not less than $2,000,000. When policies are renewed or replaced, the policy retroactive date must coincide with, or precede, start of Services on this Agreement. A claims-made policy which is not renewed or replaced must have an extended reporting period of 2 years.

ii) **Additional Requirements**

(1) Vendor must furnish the County of Cook, Cook County, Office of the Purchasing Agent, 118 N, Clark St., Room 1018, Chicago, IL 60602, a copy of Certificates of Insurance, or such similar evidence, to be in force on the date of this Agreement, and Renewal Certificates of Insurance, or such similar evidence, if the coverages have an expiration or renewal date occurring during the term of this Agreement. Vendor must submit evidence of insurance on an ACORD Certificate of Insurance Form or equivalent prior to Agreement award. The receipt of any certificate does not constitute agreement by the County that the insurance requirements in this Agreement have been fully met or that the insurance policies indicated on the certificate are in compliance with all Agreement requirements. The failure of the County to obtain certificates or other insurance evidence from Vendor is not a waiver by the County of any requirements for Vendor to obtain and maintain the specified coverages. Vendor must advise all insurers of the provisions in this Agreement regarding insurance. Non-conforming insurance does

not relieve Vendor of the obligation to provide insurance as specified in this Agreement. Nonfulfillment of the insurance conditions may constitute a violation of this Agreement, and the County retains the right to terminate this Agreement or to suspend this Agreement until proper evidence of insurance is provided.

(2) Vendor must provide for 60 days prior written notice to be given to the County in the event coverage is substantially changed, canceled or non-renewed. All deductibles or self-insured retentions on referenced insurance coverages must be borne by Vendor. Vendor agrees that insurers waive their rights of subrogation against the County of Cook, its employees, elected officials, agents or representatives.

(3) The coverages and limits furnished by Vendor in no way limit CLI&ultQIt'& liQbilitie& and responsibilities specified within this Agreement or by law. Any insurance or self-insurance programs maintained by the County of Cook apply in excess of and do not contribute with insurance provided by Vendor under this Agreement.

(4) The required insurance is not limited by any limitations expressed in the indemnification language in this Agreement or any limitation placed on the indemnity in this Agreement given as a matter of law.

(5) The Department maintains the right to request a modification, deletion, alteration or change to these requirements.

g) Indemnification

The Vendor covenants and agrees to indemnify and save harmless the County and its commissioners, officials, employees, agents and representatives, and their respective heirs, successors and assigns, from and against any and all costs, expenses, attorney's fees, losses, damages and liabilities incurred or suffered directly from any claims arising out of or incident to the performance or nonperformance of the Agreement by the Vendor, or the acts or omissions of the officers, agents, employees, contractors, subcontractors, licensees or invitees of the Vendor, unless caused by the fault or negligence of the County, if and to the extent so found by a court of competent jurisdiction.

The County acknowledges that it will be liable to the Vendor for costs, expenses, attorney's fees, losses, damages and liabilities incurred or suffered directly from any claims arising out of or incident to the performance or nonperformance of the Agreement by the County, or the acts or omissions of the officers, agents, employees, contractors, subcontractors, licensees or invitees of the County, unless caused by the fault or negligence of the Vendor, if and to the extent so found by a court of competent jurisdiction.

h) Confidentiality and Ownership of Documents

Vendor acknowledges and agrees that information regarding this Agreement is confidential and shall not be disclosed, directly, indirectly or by implication, or be used by Vendor in any way, whether during the term of this Agreement or at any time thereafter, except solely as required in the course of Vendor's performance hereunder or as may be necessary in connection with Vendor's regulatory compliance and reporting obligations. Vendor shall not have the right to compile and distribute statistical analyses and reports utilizing data derived from information or

data obtained from County without the prior written approval of County. In the event such approval is given, any such reports published and distributed by Vendor shall be furnished to County without charge. The foregoing not withstanding, the parties acknowledge that the parties have entered into various HIPAA documents. Nothing in this Agreement shall limit the permitted use or disclosure of PHI and other information as described in such HIPAA documents, as amended or replaced from time-to-time.

i) Patents, Copyrights and Licenses

Vendor agrees to hold harmless and indemnify the County, its officers, agents, employees and affiliates from any suit or proceeding brought against County based upon a claim that the ownership and/or use of equipment, hardware and software or any part thereof provided to the County or utilized in performing Vendor's services constitutes an infringement of any patent, copyright or license or any other property right. Where applicable, the County shall notify Vendor in writing of any such suit or proceeding or significant threat thereof.

In the event the use of any equipment, hardware or software or any part thereof is enjoined, Vendor with all reasonable speed and due diligence shall provide or otherwise secure for County, at the Vendor's election, one of the following: the right to continue use of the equipment, hardware or software; an equivalent system having the Specifications as provided in this Agreement; or Vendor shall modify the system or its component parts so that they become non-infringing while performing in a substantially similar manner to the original system, meeting the requirements of this Agreement.

j) Examination of Records and Audits

The Vendor agrees that the Cook County Auditor or any of its duly authorized representatives shall, until expiration of one year after the final payment under the Agreement, have the right to conduct reasonable audits of the Vendor's records in regard to claim payment and net claim payments calculated on the basis of claim payments made under the Agreement. The Vendor agrees that the Cook County Auditor or any of its duly authorized representatives shall, until expiration of three (3) years after the final payment under the Agreement, have the right to examine any books, documents, papers, canceled checks, bank statements, purveyor's and other invoices, and records of the Vendor related to the Agreement, or to Vendor's compliance with any term, condition or provision thereof. The Vendor shall be responsible for establishing and maintaining records sufficient to document the costs associated with performance under the terms of this Agreement.

The Vendor further agrees that it shall include in all of its subcontracts hereunder a provision to the effect that the subcontractor agrees that the Cook County Auditor or any of its duly authorized representatives shall, until expiration of three (3) years after final payment under the subcontract, have access and the right to examine any books, documents, papers, canceled checks, bank statements, purveyor's and other invoices and records of such subcontractor involving transactions relating to the subcontract, or to such subcontractor's compliance with any term, condition or provision thereunder or under the Agreement.

In the event the Vendor receives payment under the Agreement, reimbursement for which is later disallowed by the County, the Vendor shall promptly refund the disallowed amount to the County on request, or at the County's option, the County may credit the amount disallowed from the next payment due or to become due to the Vendor under any contract with the County.

To the extent this Agreement pertains to Deliverables which may be reimbursable under the Medicaid or Medicare Programs, Vendor shall retain and make available upon request, for a period of four (4) years after furnishing services pursuant to this Agreement, the contract, books, documents and records which are necessary to certify the nature and extent of the costs of such services if requested by the Secretary of Health and Human Services or the Comptroller General of the United States or any of their duly authorized representatives. If Vendor carries out any of its duties under the Agreement through a subcontract with a related organization involving a value of cost of $10,000.00 or more over a 12 month period, Vendor will cause such subcontract to contain a clause to the effect that, until the expiration of four years after the furnishing of any service pursuant to said subcontract, the related organization will make available upon request of the Secretary of Health and Human Services or the Comptroller General of the United States or any of their duly authorized representatives, copies of said subcontract and any books, documents, records and other data of said related organization that are necessary to certify the nature and extent of such costs. This paragraph relating to the retention and production of documents is included because of possible application of Section 1861(v)(1)(I) of the Social Security Act to this Agreement; if this Section should be found to be inapplicable, then this paragraph shall be deemed inoperative and without force and effect.

k) Subcontract Subcontracting or Assignment of Agreement or Agreement Funds

Once awarded, this Agreement shall not be subcontracted or assigned, in whole or in part, without the advance written approval of the Purchasing Agent, which approval shall be granted or withheld at the sole discretion of the Purchasing Agent. In no case, however, shall such approval relieve the Vendor from its obligations or change the terms of the Agreement. The Vendor shall not transfer or assign any Agreement funds or any interest therein due or to become due without the advance written approval of the Purchasing Agent. The unauthorized subcontracting or assignment of the Agreement, in whole or in part, or the unauthorized transfer or assignment of any Agreement funds, either in whole or in part, or any interest therein, which shall be due or are to become due the Vendor shall have no effect on the County and are null and void.

ARTICLE 4) TERM OF PERFORMANCE

a) Term of Performance

This Agreement takes effect when approved by the Cook County Board and its term shall begin on December 1, 2011 ("Effective Date") and continue until November 30, 2013 or until this Agreement is terminated in accordance
with its terms, whichever occurs first.

b) Agreement Extension Option

The Purchasing Agent may at any time before this Agreement expires elect to extend this Agreement for up to 2 additional one-year periods under the same terms and conditions as this original Agreement, except as provided otherwise in this Agreement, by notice in writing to Vendor. After notification by the Purchasing Agent, this Agreement must be modified to reflect the time extension in accordance with the provisions of Section 1 0.c.

ARTICLE 5) COMPENSATION

a) Basis of Payment

The County will pay Vendor according to the Schedule of Compensation in the attached Exhibit 2 for the successful completion of services.

b) Method of Payment

All invoices submitted by the Vendor shall be in accordance with the cost provisions according to the Schedule of Compensation in the attached Exhibit 2. The invoices shall contain a detailed description of the Deliverables for which payment is requested. All invoices shall reflect the amounts invoiced by and the amounts paid to the Vendor as of the date of the invoice, and shall be submitted together with a properly completed County Voucher form (29A). Invoices for new charges shall not include past due amounts, if any, which amount must be set forth on a separate invoice. No payments shall be made with respect to invoices which do not include the County Voucher form or which otherwise fail to comply with the requirements of this paragraph. Vendor shall not be entitled to invoice the County for any late fees or other penalties.

c) Non-Appropriation

If no funds or insufficient funds are appropriated and budgeted in any fiscal period of the County for payments to be made under this Agreement, then the County will notify Vendor in writing of that occurrence, and this Agreement will terminate on the earlier of the last day of the fiscal period for which sufficient appropriation was made or whenever the funds appropriated for payment under this Agreement are exhausted, but in no event less than 90 days following receipt of the notice. Payments for Services completed to the date of notification will be made to Vendor.

d) Taxes

Federal Excise Tax does not apply to materials purchased by the County by virtue of Exemption Certificate No. 36-75-0038K. Illinois Retailers' Occupation Tax, Use Tax and Municipal Retailers' Occupation Tax do not apply to deliverables, materials or services purchased by the County by virtue of statute. The price or prices quoted herein shall include any and all other federal and/or state, direct and/or indirect taxes which apply to this Agreement. The County's State of Illinois Sales Tax Exemption Identification No. is E-9998-2013-05.

ARTICLE 6) DISPUTES

Any dispute arising under the Agreement between the County and Vendor shall be reviewed by the Purchasing Agent. The complaining party shall submit a written statement detailing the dispute and specifying the specific relevant Agreement provision(s) to the Purchasing Agent. Upon request of the Purchasing Agent, the party complained against shall respond to the complaint in writing within five business days of such request. The Purchasing Agent will reduce his recommendations to writing and mail or otherwise furnish a copy thereof to the Vendor and the Director. Dispute resolution as provided herein shall be a condition precedent to any other action at law or in equity. Notwithstanding a dispute, Vendor shall continue to discharge all its obligations, duties and responsibilities set forth in the Agreement during any dispute resolution proceeding unless otherwise agreed to by the County in writing.

ARTICLE 7) COMPLIANCE WITH ALL LAWS

The Vendor and County shall observe and comply with the laws, ordinances, regulations and codes of the Federal, State, County and other local government agencies applicable to the performance of the Agreement including, but not limited to, those County Ordinances set forth in the Certifications attached hereto and incorporated herein. Assurance of compliance with this requirement by the Vendor's and County's employees, agents or subcontractors shall be the responsibility of the Vendor and County, respectively.

The Vendor shall secure and pay for all federal, state and local licenses and permits the Vendor requires to perform the Services under this Agreement.

This Section modifies Article 10.c, Modifications and Amendments to include the following provisions:

A. Illinois Department of Financial and Professional Regulation, Division of Insurance Approval. The obligations of Vendor pursuant to this Agreement are conditioned upon Vendor procuring all required approvals by the Director of the Division of Insurance of the Illinois Department of Financial and Professional Regulation. The eventual County approved and DOI approved Vendor's Benefit Documents shall prevail in the event of a conflict.

B. Amendment to Conform With Applicable Law. Any provision of this Agreement which is in conflict with applicable Illinois or federal statutes or regulations is hereby amended to conform with the minimum requirements of such statutes or regulations and the County agrees that the Vendor may make such changes, upon thirty (30) days' advance written notice in each case to the County, to any provision of this Agreement as may be necessary to conform same to such statutes and regulations and directives of regulatory authorities with respect thereto. However, in no event shall any such changes increase Premiums or decrease benefits without the prior consent of the County.

C. Mandated Increase in Benefits. In the event that any binding federal, state or local legislation or regulations promulgated hereafter mandate an increase in the benefits provided for under this Agreement, the Vendor agrees to use its best efforts to incorporate such benefit increases without any additional cost to the County. However, if, based on a sound actuarial analysis the Vendor is unable reasonably to incorporate such increases (or provide for such decreases) without an increase in the Premiums paid by the County, Vendor may request that the County consent to an increase in Premiums. However, in no event shall such increase in Premiums be effective prior to the last effective date provided under the legislation or regulations which mandated the subject increase in benefits. In the event that the Vendor has requested an increase in Premiums under this paragraph and the County has not consented to the requested increase, then the County and the Vendor shall negotiate in good faith to agree upon an increase which is acceptable to both taking into consideration all relevant factors including, but not limited to, actual cost information and projections and actual claims experience with respect to Enrollees and projected claims experience with respect to Enrollees. If, after good faith negotiations, the parties are unable to reach agreement, the Vendor may, by written notice to the County, terminate this Agreement upon ninety (90) days prior written notice to the County.

D. Compliance with Current Law. Notwithstanding any other provision of this Agreement, to the extent any of the Plan Options are not in minimum compliance with federal, state or local legislation or regulations promulgated thereunder in effect as of the Effective Date of this Agreement, this Agreement, including Vendor's Benefit Documents, shall be promptly amended as necessary to achieve minimum compliance at no additional cost to the County.

ARTICLE 8) SPECIAL CONDITIONS

a) Representations

In connection with signing and carrying out this Agreement, Vendor:

i) agrees that Vendor is appropriately licensed under Illinois law to perform the Services required under this Agreement and will perform no Services for which a professional license is required by law and for which Vendor is not appropriately licensed;

ii) agrees it is financially solvent; it and each of its employees, agents and, to its knowledge, Subcontractors of any tier are competent to perform the Services required under this Agreement; and Vendor is legally authorized to execute and perform or cause to be performed this Agreement under the terms and conditions stated in this Agreement;

iii) agrees that it will not knowingly use the services of any ineligible consultant or Subcontractor for any purpose in the performance of its Services under this Agreement;

iv) agrees that Vendor and, to its knowledge, its Subcontractors are not in default at the time this Agreement is signed, and have not been considered by the Purchasing Agent to have, within 5 years immediately preceding the date of this Agreement, been found to be in default on any contract awarded by the County ;

v) represents that it has carefully examined and analyzed the provisions and requirements of this Agreement; it understands the nature of the Services required; from its own analysis it has satisfied itself as to the nature of all things needed for the performance of this Agreement; and this Agreement is feasible of performance in accordance with all of its provisions and requirements,;

vi) acknowledges that any certification, affidavit or acknowledgment made under oath in connection with this Agreement is made under penalty of perjury and, if false, is also cause for termination under Sections 9.1 and 9.3.

b) Ethics

i) In addition to the foregoing representations, Vendor agrees:

(1) no officer, agent or employee of the County is employed by Vendor or has a financial interest directly or indirectly in this Agreement or the compensation to be paid under this Agreement except as may be permitted in writing by the Board of Ethics.

(2) no payment, gratuity or offer of employment will be made in connection with this Agreement by or on behalf of any Subcontractors to the prime Vendor or higher tier Subcontractors or anyone associated with them, as an inducement for the award of a subcontract or order.

d) Business Documents

At the request of the County, Vendor must provide copies of its latest articles of incorporation, by-laws and resolutions authorizing its execution, delivery or performance of this Agreement (if required), or partnership or joint venture agreement, as applicable.

e) Conflicts of Interest

i) Vendor acknowledges that no member of the governing body of the County or other unit of government and no other officer, employee or agent of the County or other unit of government who exercises any functions or responsibilities in connection with the Services to which this Agreement pertains is permitted to have any personal interest, direct or indirect, in this Agreement. No member of or delegate to the Congress of the United States or the Illinois General Assembly and no Commissioner of the Cook County Board or County employee is allowed to be admitted to any share or part of this Agreement or to any financial benefit to arise from it.
Vendor agrees to inform the County on a timely basis of the Vendor's interests, if any, which are incompatible with any interest of the County. The Vendor shall take notice of and comply, to the extent applicable, with the Cook County Lobbyist Registration Ordinance (Sec. 2-621 of the Cook County Code of Ordinances). The Vendor shall not, under circumstances which might reasonably be interpreted as an attempt to influence the recipient in the conduct of its duties, accept any gratuity or special favors from individuals or organizations with whom the Vendor is doing business or proposing to do business, under the Agreement. The Vendor shall not use for personal gain or make other improper use or privileged information which is

acquired in connection with the Agreement.

f) Non-Liability of Public Officials

Vendor and any assignee or Subcontractor of Vendor must not charge any official, employee or agent of the County personally with any liability or expenses of defense or hold any official, employee or agent of the County personally liable to them under any term or provision of this Agreement or because of the County's execution, attempted execution or any breach of this Agreement.

ARTICLE 9) EVENTS OF DEFAULT, REMEDIES AND TERMINATION

a) By Vendor.

Each of the following shall constitute an Event of Default under this Agreement:

1. Bankruptcy or Insolvency. If Vendor becomes insolvent or generally fails to pay, or admits in writing its inability to pay, debts as they become due; or if Vendor applies for, consents to, or acquiesces in the appointment of a trustee, receiver or other custodian, or makes a general assignment for the benefit of creditors; or, in the absence of such an application, consent or acquiescence, a trustee, receiver or other custodian is appointed for the Vendor or for a substantial part of the property of the Vendor and is not discharged within sixty (60) days; or any bankruptcy, reorganization, debt arrangement, or other case or proceeding under any bankruptcy or insolvency law, or any dissolution or liquidation proceeding, is commenced, and if such case or proceeding is not commenced by the Vendor, it is consented to or acquiesced to by the Vendor or remains pending for sixty (60) days and is not dismissed or if the Vendor takes any corporate action to authorize, or in furtherance of, the foregoing.

2. Noncompliance with Agreement terms. Vendor's failure to pay or perform on a timely basis the benefits and/or services required to be provided under this Agreement or Vendor's breach of a material term of this Agreement.

3. Loss of Necessary Authority to Conduct Business. Loss by Vendor of any federal, state or local license, permit, certificate or any other required authority to conduct business in accordance with the terms of this Agreement.

b) By County.

Each of the following shall constitute an Event of Default under this Agreement:

1. Nonpayment of Premiums by County. Material failure on the part of the County to make timely payment of Premiums in accordance with the terms of this Agreement (excluding Premium payments which are in dispute by the County).

2. Noncompliance with Agreement terms. The County's breach of a material term of this Agreement.

c) Notice of Default.

If any Event of Default described in this Special Condition SC-12 shall occur, the non-defaulting party shall provide a written notice to the defaulting party specifying the nature of such default. The defaulting party shall have thirty (30) days within which to cure such default.

d) Right to Terminate.

If a defaulting party has failed to cure a default within thirty (30) days after notice of default, the non-defaulting party may terminate this Agreement upon thirty (30) days' prior written notice of termination. Such right of termination is in addition to and not a limitation of any other remedies available to either party.

e) Transition Upon Expiration or Termination.

Upon expiration or termination of this Agreement by either party, Vendor agrees to cooperate and use all necessary efforts for an orderly and efficient transition of services with the County's new or existing health benefits contractors.

Vendor's full cooperation will be required at no additional cost to the County or the Enrollees. In the event a transition is required, Vendor shall:

1. provide to the County or to another health benefits contractor as designated by the County, all nonproprietary information within its computer files or other documents and records relating to all Enrollees, in a format which is mutually agreed upon;

2. provide the County with a summary of all pending claims and the status thereof;

3. provide all Vendor reports and information required pursuant to the terms of this Agreement;

4. make available its personnel to assist with the resolution of any transition issues raised by the County or by Enrollees;

5. provide full and complete cooperation to the County and any of its authorized agents with regard to completion of any pending County audit.

In the event that a new health benefits contractor is selected by the County, Vendor acknowledges and agrees that continuity of service is critical and that time is of the essence with regard to transition of services. Vendor further acknowledges and agrees that the County and the Enrollees will be irreparably harmed if an orderly and efficient transition of services does not occur. Vendor shall provide full cooperation and assistance in the event of a transition. Vendor acknowledges agrees that any enforcement of the provisions of this Agreement by the County may be had by mandatory injunction in the Circuit Court of Cook County, Illinois.

f) Early Termination

In addition to termination under Sections 9.1 and 9.2 of this Agreement, the County may terminate this Agreement, or all or any portion of the Services to be performed under it, at any time by 180 days prior notice in writing from the County to Vendor. The County will give notice to Vendor in accordance with the provisions of Article 11.

Payment for the Services performed before the effective date of such termination shall be based upon the premium or other fees as set forth in Exhibit 2 Compensation due through the date of termination, at the rates then in effect. The payment so made to Vendor is in full settlement for all Services satisfactorily performed under this Agreement.

If County exercises this right, the provisions set forth in 9(E), Transition Upon Expiration or Termination, shall apply.

Vendor must include in its contracts with Subcontractors engaged solely to provide Services under this Agreement an early termination provision in form and substance equivalent to this early termination provision to prevent claims against the County arising from termination of subcontracts after the early termination. Vendor will not be entitled to make any early termination claims against the County resulting from any subcontractors claims against Vendor or County to the extent inconsistent with this provision.

g) Delays

Vendor agrees that no charges or claims for damages shall be made by Vendor for any delays or hindrances from any cause whatsoever during the progress of any portion of this Agreement.

h) Prepaid Fees

In the event this Contract is terminated by either party, for cause or otherwise, and the County has prepaid for any Deliverables, Vendor shall refund to the County, on a prorated basis to the effective date of termination, all amounts prepaid for Deliverables not actually provided as of the effective date of the termination. The refund shall be made within fourteen (14) days of the effective date of termination.

ARTICLE 10) GENERAL CONDITIONS

a) Entire Agreement

i) General

This Agreement, and the exhibits attached to it and incorporated in it, constitute the entire agreement between the parties and no other warranties, inducements, considerations, promises or interpretations are implied or impressed upon this Agreement that are not expressly addressed in this Agreement.

ii) No Collateral Agreements

Each party acknowledges that, except only for those representations, statements or promises expressly contained in this Agreement, the Group Administration Document, Benefit Program Application, Certificate Booklets and individual applications, if any, and any exhibits attached to it and incorporated by reference therein, no representation, statement or promise, oral or in writing, of any kind whatsoever, by a party , its officials, agents or employees, has induced the other party to enter into this Agreement or has been relied upon by the other party, including any with reference to: (i) the meaning, correctness, suitability or completeness of any provisions or requirements of this Agreement; (ii) the nature of the Services to be performed; (iii) the nature, quantity, quality or volume of any materials, equipment, labor and other facilities needed for the performance of this Agreement; (iv) the general conditions which may in any way affect this Agreement or its performance; (v) the compensation provisions of this Agreement; or (vi) any other matters, whether similar to or different from those referred to in (i) through (vi) immediately above, affecting or having any connection with this Agreement, its negotiation, any discussions of its performance or those employed or connected or concerned with it.

iii) No Omissions

Each party acknowledges that such party was given an opportunity to review all documents forming this Agreement before signing this Agreement in order that it might request inclusion in this Agreement of any statement, representation, promise or provision that it desired or on that it wished to place reliance. Each party did so review those documents, and either every such statement, representation, promise or provision has been included in this Agreement or else, if omitted, such party relinquishes the benefit of any such omitted statement, representation, promise or provision and is willing to perform this Agreement in its entirety without claiming reliance on it or making any other claim on account of its omission.

b) Counterparts

This Agreement is comprised of several identical counterparts, each to be fully signed by the parties and each to be considered an original having identical legal effect.

c) Modifications and Amendments

The parties may from time to time during the term of the Agreement make modifications and amendments to the Agreement but only as provided in this section. Such modifications and amendments shall only be made by mutual agreement in writing and the review and approval by the Illinois Department Of Insurance. Modifications and amendments which individually or cumulatively result in additional cost of $25,000.00 or greater or which extend the term of the Agreement by thirty (30) days or more shall not be deemed as authorized without the approval of the Cook County Board of Commissioners. Modifications and amendments which increase cost by less than $25,000.00 or which do not extend the term of the Agreement by more than thirty (30) days may only be made with the written approval of the Purchasing Agent.

Subject to the foregoing, the Purchasing Agent may, by written order, make changes with respect to the dates of delivery and places of performance of the Agreement, provided that any such changes

shall not increase the Agreement price or the time required for Agreement performance.

Vendor is hereby notified that, except for modifications and amendments which are made in accordance with this Section 10.c., Modifications and Amendments, no County department or employee thereof has authority to make any modification or amendment to this Agreement.

d) Governing Law and Jurisdiction

This Agreement shall be governed by and construed under the laws of the State of Illinois. The Contractor irrevocably agrees that, subject to the County's sole and absolute election to the contrary, any action or proceeding in any way, manner or respect arising out of the Contract, or arising from any dispute or controversy arising in connection with or related to the Contract, shall be litigated only in courts within the Circuit Court of Cook County, State of Illinois, and the Contractor consents and submits to the jurisdiction thereof. In accordance with these provisions, Contractor waives any right it may have to transfer or change the venue of any litigation brought against it by the County pursuant to this Contract.

e) Severability

If any provision of this Agreement is held or considered to be or is in fact invalid, illegal, inoperative or unenforceable as applied in any particular case in any jurisdiction or in all cases because it conflicts with any other provision or provisions of this Agreement or of any constitution, statute, ordinance, rule of law or public policy, or for any other reason, those circumstances do not have the effect of rendering the provision in question invalid, illegal, inoperative or unenforceable in any other case or circumstances, or of rendering any other provision or provisions in this Agreement invalid, illegal, inoperative or unenforceable to any extent whatsoever. The invalidity, illegality, inoperativeness or unenforceability of any one or more phrases, sentences, clauses or sections in this Agreement does not affect the remaining portions of this Agreement or any part of it.

f) Assigns

All of the terms and conditions of this Agreement are binding upon and inure to the benefit of the parties and their respective legal representatives, successors and assigns.

g) Cooperation

Each party shall provide commercially reasonable cooperation and assistance to the other party in connection with this Agreement.

h) Waiver

Nothing in this Agreement authorizes the waiver of a requirement or condition contrary to law or ordinance or that would result in or promote the violation of any federal, state or local law or ordinance.

Whenever under this Agreement a party waives the other party's performance in any respect or waives a requirement or condition to either party's performance, the waiver so granted, whether express or implied, only applies to the particular instance and is not a waiver forever or for subsequent instances of the performance, requirement or condition. No such waiver is a modification of this Agreement regardless of the number of times a party may have waived the performance, requirement or condition. Such waivers must be provided in writing.

i) Independent Contractor

This Agreement is not intended to and will not constitute, create, give rise to, or otherwise recognize a joint venture, partnership, corporation or other formal business association or organization of any kind between Vendor and the County. The rights and the obligations of the parties are only those expressly set forth in this Agreement. Vendor must perform under this Agreement as an independent contractor and not as a representative, employee, agent, or partner of the County.

This Agreement is between the County and an independent contractor and, if Vendor is an individual, nothing provided for under this Agreement constitutes or implies an employer-employee relationship such that:

i) The County will not be liable under or by reason of this Agreement for the payment of any compensation award or damages in connection with the Vendor performing the Services required under this Agreement.

ii) Vendor is not entitled to membership in the County Pension Fund, Group Medical Insurance Program, Group Dental Program, Group Vision Care, Group Life Insurance Program, Deferred Income Program, vacation, sick leave, extended sick leave, or any other benefits ordinarily provided to individuals employed and paid through the regular payrolls of the County.

iii) The County is not required to deduct or withhold any taxes, FICA or other deductions from any compensation provided to the Vendor.

ARTICLE 11) NOTICES

All notices required pursuant to this Agreement shall be in writing and addressed to the parties at their respective addresses set forth below. All such notices shall be deemed duly given if hand delivered or if deposited in the United States mail, postage prepaid, registered or certified, return receipt requested. Notice as provided herein does not waive service of summons or process.

If to the County:

Cook County Department of Risk Management
118 N Clark St, Rm 1072
Chicago, Illinois 60602
Attention: Department Director

and

COOK COUNTY PURCHASING AGENT
118 North Clark Street. Room 1018
Chicago, Illinois 60602
(Include County Contract Number on all notices)

If to Vendor: Blue Cross Blue Shield of Illinois
300 East Randolph Street
Chicago, Illinois 60601
Attention: Sandra Gonzalez, Principal Account Executive

Changes in these addresses must be in writing and delivered in accordance with the provisions of this Article 11. Notices delivered by mail are considered received three days after mailing in accordance with this Article 11. Notices delivered personally are considered effective upon receipt. Refusal to accept delivery has the same effect as receipt.

ARTICLE 12) AUTHORITY

Execution of this Agreement by Vendor is authorized by a resolution of, or general grant of authority by, its Board of Directors, if a corporation, or similar governing document, and the signature(s) of each person signing on behalf of Vendor have been made with complete and full authority to commit Vendor to all terms and conditions of this Agreement.

Execution of this Agreement by the County is authorized by a resolution of, or general grant of authority by, its Board of Commissioners, and the signature(s) of each person signing on behalf of the County have been made with complete and full authority to commit the County to all terms and conditions of this Agreement.

ECONOMIC DISCLOSURE STATEMENT
AND EXECUTION DOCUMENT
INDEX

Section	Description	Pages
	Instructions for Completion of EDS	EDS 1-2
1	MBE/WBE Utilization Plan	EDS 3-4
2	Letter of Intent	EDS 4-5
3	Petition for Reduction/Waiver of MBE/WBE Participation Goals	EDS 6-8
4	Certifications	EDS 9-10
5	Economic and Other Disclosures, Affidavit of Child Support Obligations and Disclosure of Ownership Interest	EDS 11-15

INSTRUCTIONS FOR COMPLETION OF ECONOMIC DISCLOSURE STATEMENT AND EXECUTION DOCUMENT

This Economic Disclosure Statement and Execution Document ("EDS") is to be completed and executed by every Bidder on a County contract, every party responding to a Request for Proposals or Request for Qualifications "(Proposer"), and others as required by the Purchasing Agent. If the Undersigned is awarded a contract pursuant to the procurement process for which this EDS was submitted (the "Contract"), this Economic Disclosure Statement and Execution Document shall stand as the Undersigned's execution of the Contract.

Definitions. Capitalized terms used in this EDS and not otherwise defined herein shall have the meanings given to such terms in the Instructions to Bidders, General Conditions, Request for Proposals, Request for Qualifications, or other documents, as applicable.

> ***"Affiliated Entity"*** means a person or entity that, directly or indirectly: controls the Bidder, is controlled by the Bidder, or is, with the Bidder, under common control of another person or entity. Indicia of control include, without limitation, interlocking management or ownership; identity of interests among family members; shared facilities and equipment; common use of employees; and organization of a business entity following the ineligibility of a business entity to do business with the County under the standards set forth in the Certifications included in this EDS, using substantially the same management, ownership or principals as the ineligible entity.
>
> ***"Bidder," "Proposer," "Undersigned,"*** or ***"Applicant,"*** is the person or entity executing this EDS. Upon award and execution of a Contract by the County, the Bidder, Proposer, Undersigned or Applicant, as the case may be, shall become the Contractor or Contracting Party.
>
> ***"Proposal,"*** for purposes of this EDS, is the Undersigned's complete response to an RFP/RFQ, or if no RFQ/RFP was issued by the County, the "Proposal" is such other proposal, quote or offer submitted by the Undersigned, and in any event a "Proposal" includes this EDS .
>
> ***"Code"*** means the Code of Ordinances, Cook County, Illinois available through the Cook County Clerk's Office website (http://www.cookctyclerk.com/sub/ordinances.asp). This page can also be accessed by going to www.cookctyclerk.com, clicking on the tab labeled "County Board Proceedings," and then clicking on the link to "Cook County Ordinances."
>
> ***"Contractor"*** or ***"Contracting Party"*** means the Bidder, Proposer or Applicant with whom the County has entered into a Contract.
>
> ***"EDS"*** means this complete Economic Disclosure Statement and Execution Document, including all sections listed in the Index and any attachments.
>
> ***"Lobby"*** or "lobbying" means to, for compensation, attempt to influence a County official or County employee with respect to any County matter.
>
> ***"Lobbyist"*** means any person or entity who lobbies.
>
> ***"Prohibited Acts"*** means any of the actions or occurrences which form the basis for disqualification under the Code, or under the Certifications hereinafter set forth.

Sections 1 through 3: MBE/WBE Documentation. Sections 1 and 2 must be completed in order to satisfy the requirements of the County's MBE/WBE Ordinance, as set forth in the Contract Documents, if applicable. If the Undersigned believes a waiver is appropriate and necessary, Section 3, the Petition for Waiver of MBE/WBE Participation must be completed.

Section 4: Certifications. Section 4 sets forth certifications that are required for contracting parties under the Code. Execution of this EDS constitutes a warranty that all the statements and certifications contained, and all the facts stated, in the Certifications are true, correct and complete as of the date of execution.

Section 5: Economic and Other Disclosures Statement. Section 5 is the County's required Economic and Other Disclosures Statement form. Execution of this EDS constitutes a warranty that all the information provided in the EDS is true, correct and complete as of the date of execution, and binds the Undersigned to the warranties, representations, agreements and acknowledgements contained therein.

Sections 6, 7, 8: Execution Forms. The Bidder executes this EDS, and the Contract, by completing and signing three copies of the appropriate Signature Page. Section 6 is the form for a sole proprietor; Section 7 is the form for a partnership or joint venture; and Section 8 is the form for a corporation. Proper execution requires **THREE ORIGINALS**; therefore, the appropriate Signature Page must be filled in, three copies made, and all three copies must be properly signed, notarized and submitted. The forms may be printed and completed by typing or hand writing the information required. The County is in the process of converting these forms into a format that may be downloaded and completed on the user's computer. Once this feature is available, those having the necessary software may follow the instructions set forth below under the heading "Instructions for Completing PDF Forms."

Required Updates. The information provided in this EDS will be kept current. In the event of any change in any information provided, including but not limited to any change which would render inaccurate or incomplete any certification or statement made in this EDS, the Undersigned will supplement this EDS up to the time the County takes action, by filing an amended EDS or such other documentation as is requested.

Additional Information. The County's Governmental Ethics and Campaign Financing Ordinances, impose certain duties and obligations on persons or entities seeking County contracts, work, business, or transactions. For further information please contact the Director of Ethics at (312) 603-4304 (69 W. Washington St. Suite 3040, Chicago, IL 60602) or visit our web-site at www.cookcountygov.com and go to the Ethics Department link. The Bidder must comply fully with the applicable ordinances.

MBE/WBE UTILIZATION PLAN
Section 1

BIDDER/PROPOSER HEREBY STATES that all MBE/WBE firms included in this Plan are certified MBEs/WBEs by at least one of the entities listed in the General Conditions.

I. **BIDDER/PROPOSER MBE/WBE STATUS:** (check the appropriate line)

_____ Bidder/Proposer is a certified MBE or WBE firm. (If so, attach copy of appropriate Letter of Certification.)

_____ Bidder/Proposer is a Joint Venture and one or more Joint Venture partners are certified MBEs or WBEs, (If so, attach copies of Letter(s) of Certification, a copy of Joint Venture Agreement clearly describing the role of the MBE/WBE firm(s) and its ownership interest in the Joint Venture and a completed Joint Venture Affidavit – available from the Office of Contract Compliance.)

X_____ Bidder/Proposer is not a certified MBE or WBE firm, nor a Joint Venture with MBE/WBE partners, but will utilize MBE and WBE firms either Directly or Indirectly in the performance of the Contract. (If so, complete Sections II and III).

II. In **Direct Participation of MBE/WBE Firms**

MBEs/WBEs will perform as subcontractors/suppliers/consultants include the following:

MBE/WBE Firm: A&R Janitorial Service Inc.

Address: 5234 W. 25th Street Cicero, Illinois 60804

E-mail: dpintor@arjanitorial.com

Contact Person: Deborah Pintor Phone: (708)656-8300

Dollar Amount Participation: $ 262,752.76

Percent Amount of Participation: 05 %

*Letter of Intent attached? Yes ✓ No _____

*Letter of Certification attached? Yes _____ No _____

MBE/WBE Firm: Creative Printing Services, Inc.

Address: 1701 Birchwood Ave. Des Plaines, Illinois 60018

E-mail: mgregory@creativepsi.com

Contact Person: R. Michael Gregory Phone: (847)803-2800

Dollar Amount Participation: $ 869,105.29

Percent Amount of Participation: 15 %

*Letter of Intent attached? Yes ✓ No _____

*Letter of Certification attached? Yes _____ No _____

Attach additional sheets as needed.

***Where goals have not been achieved through Direct Participation, Bidder/Proposer shall include documentation outlining efforts to achieve Direct Participation at the time of Bid/Proposal submission.**

II. Indirect Participation of MBE/WBE Firms

NOTE: **This section need not be completed if the MBE/WBE goals have been met through Direct Participation.** However, Indirect Participation will only be considered after all efforts to achieve Direct Participation have been exhausted. Only after written documentation of Good Faith Efforts is received will Indirect Participation be considered.

MBEs/WBEs will perform as subcontractors/suppliers/consultants include the following:

MBE/WBE Firm: Innovative Systems Group

Address: 799 Roosevelt Rd. Bldg 4-109

E-mail: joes@innovativesys.com

Contact Person: Joselito Salas Phone: (630)858-8500

Dollar Amount Participation: $ 586,140.77

Percent Amount of Participation: 10 %

*Letter of Intent attached? Yes ✓ No ____

*Letter of Certification attached? Yes ____ No ____

MBE/WBE Firm: Terrance Electric Company

Address: 1003 Fairway Drive Bensenville, Illinois 60106

E-mail: jshimkus@terranceelectric.com

Contact Person: Judy Shimkus Phone: (630)758-0011

Dollar Amount Participation: $ 303,176.26

Percent Amount of Participation: 05 %

*Letter of Intent attached? Yes ✓ No ____

*Letter of Certification attached? Yes ____ No ____

Attach additional sheets as needed.

***All Letters of Intent, Letters of Certification and documentation of Good Faith Efforts omitted from this bid/proposal must be submitted to the Office of Contract Compliance so as to assure receipt by the Contract Compliance Administrator not later than three (3) business days after bid opening or proposal due date.**

COOK COUNTY LETTER OF INTENT
(Section 2)

FROM MBE/WBE TO PERFORM AS SUBCONTRACTOR, SUPPLIER AND/OR CONSULTANT

Contract Title & Number Employer-Sponsor Health / 11 87 0040 (Health)

From A & R Janitorial Services
(MBE/WBE Firm)

To Health Care Service Corporation
(Bidder/Proposer Firm) and the County of Cook

The Undersigned is prepared to provide the following services, supplies and project in connection with the above named contract (the "Contract"):

Each service performed and /or item supplied will be detailed under Description of Service/Supply and Project with all services/items totaled under Fee/Cost to equal the full dollar amount of the Letter of Intent. ***All services performed and/or supplies provided must be directly related to this specific Cook County contract and must not include any services/supplies related to any other government contract.***

Description of Service/Supply/Project	Fee/Cost	
1 Janitorial Services	$262,752.76	.05 %
2.	$	%
3	$	%
4.	$	%
Total:	$ 262,752.76	.05 %

THE UNDERSIGNED PARTIES AGREE that this Letter of Intent will become a binding Subcontract Agreement conditioned upon the Bidder/Proposer's receipt of a signed contract from the County of Cook. The Undersigned Parties do also certify that they did not affix their signatures to this document until all areas under Description of Service/Supply and Fee/Cost were completed.

Upon Penalty of perjury, I Helen Velasquez (print name)

the COO (title) and duly authorized representative

of the A+R Janitorial Service, Inc. (MBE/WBE firm) affirm

that the foregoing information is true and correct and the services, supplies, and/or project indicated above will be supplies/performed for the above indicated total dollar amount $ 262,752.76 which represents the above indicated total percentage .05 % for the contract amount $ 5,774,785.95

(Signature of affiant) 5/25/2011 (Date)

Subscribed and sworn to before me this 25th day of MAY 20 11

(Notary's Signature) (Notary Seal)

OFFICIAL SEAL
TERESA M. MARTINEZ
NOTARY PUBLIC, STATE OF ILLINOIS
MY COMMISSION EXPIRES 7-3-2011

04 09

COOK COUNTY LETTER OF INTENT
FROM BIDDER OR PROPOSER TO COOK COUNTY

Upon penalty of perjury, Monica Billinger (print name),

the Manager Corporate Supplier Diversity (*title*) and duly authorized

representative of Health Care Service Corporation (*Bidder Proposer firm*),

affirm that the foregoing information is true and correct and the services, supplies, and/or project indicated above will be supplied/performed for the above indicated total dollar amount $ 202,752.76, which represents the above indicated total percentage 05 % for the contract amount $ 5,774,785.95.

Monica Billinger
(Signature of affiant)

5 / 26 / 11
(Date)

Subscribed and sworn to before me this 26th day of May, 2011.

Maria Zavala
(Notary's Signature)

OFFICIAL SEAL
MARIA ZAVALA
NOTARY PUBLIC - STATE OF ILLINOIS
MY COMMISSION EXPIRES:03/18/12
(Notary Seal)

COOK COUNTY LETTER OF INTENT
(Section 2)

FROM MBE/WBE TO PERFORM AS SUBCONTRACTOR, SUPPLIER AND/OR CONSULTANT

Contract Title & Number: Employer-Sponsor Health / 11-87-004Q (Health)

From: Creative Printing Services, Inc.
(MBE/WBE Firm)

To: Health Care Service Corporation and the County of Cook
(Bidder/Proposer Firm)

The Undersigned is prepared to provide the following services, supplies and project in connection with the above named contract (the "Contract"):

Each service performed and /or item supplied will be detailed under Description of Service/Supply and Project with all services/items totaled under Fee/Cost to equal the full dollar amount of the Letter of Intent. ***All services performed and/or supplies provided must be directly related to this specific Cook County contract and must not include any services/supplies related to any other government contract.***

Description of Service/Supply/Project	Fee/Cost	
1. Printing and Fulfillment	$ 869,105.29	15 %
2.	$	%
3.	$	%
4.	$	%
Total:	$ 869,105.29	15 %

THE UNDERSIGNED PARTIES AGREE that this Letter of Intent will become a binding Subcontract Agreement, conditioned upon the Bidder/Proposer's receipt of a signed contract from the County of Cook. The Undersigned Parties do also certify that they did not affix their signatures to this document until all areas under Description of Service/Supply and Fee/Cost were completed.

Upon Penalty of perjury, I Hayes McNeal (*print name*)

the CEO (*title*) and duly authorized representative

of the Creative Printing Services, Inc. (MBE/WBE *firm*) affirm

that the foregoing information is true and correct and the services, supplies, and/or project indicated above will be supplies/performed for the above indicated total dollar amount $ 869,105.29 which represents the above indicated total percentage 15 % for the contract amount $ 5,774,785.95.

(Signature of affiant) 5/25/11 (Date)

Subscribed and sworn to before me this 25th day of May, 20 11

(Notary's Signature) Exp 3-28-15

(Notary Seal)
Official Seal
Joy C Graser
Notary Public State of Illinois
My Commission Expires 03/28/2015

04.09

COOK COUNTY LETTER OF INTENT
FROM BIDDER OR PROPOSER TO COOK COUNTY

Upon penalty of perjury, Monica Billinger (print name),

the Manager Corporate Supplier Diversity (*title*) and duly authorized

representative of Health Care Service Corporation (*Bidder Proposer firm*),

affirm that the foregoing information is true and correct and the services, supplies, and/or project indicated above will be supplied/performed for the above indicated total dollar amount $869,105.29, which represents the above indicated total percentage 15 % for the contract amount $ 5,774,785.95.

Monica Billinger
(Signature of affiant)

5/26/11
(Date)

Subscribed and sworn to before me this 26th day of May, 2011.

Maria Zavala
(Notary's Signature)

(Notary Seal)
OFFICIAL SEAL
MARIA ZAVALA
NOTARY PUBLIC - STATE OF ILLINOIS
MY COMMISSION EXPIRES:03/18/12

COOK COUNTY LETTER OF INTENT
(Section 2)

FROM MBE/WBE TO PERFORM AS SUBCONTRACTOR, SUPPLIER AND/OR CONSULTANT

Contract Title & Number: Employer-Sponsor Health / 11-87-004Q (Health)

From: Innovative Systems Group
(MBE/WBE Firm)

To: Health Care Service Corporation and the County of Cook
(Bidder/Proposer Firm)

The Undersigned is prepared to provide the following services, supplies and project in connection with the above named contract (the "Contract"):

Each service performed and /or item supplied will be detailed under Description of Service/Supply and Project with all services/items totaled under Fee/Cost to equal the full dollar amount of the Letter of Intent. ***All services performed and/or supplies provided must be directly related to this specific Cook County contract and must not include any services/supplies related to any other government contract.***

Description of Service/Supply/Project	Fee/Cost	
1. IT Contract Labor	$ 586,140.77	10 %
2.	$	%
3.	$	%
4.	$	%
Total:	$ 586,140.77	10 %

THE UNDERSIGNED PARTIES AGREE that this Letter of Intent will become a binding Subcontract Agreement conditioned upon the Bidder/Proposer's receipt of a signed contract from the County of Cook. The Undersigned Parties do also certify that they did not affix their signatures to this document until all areas under Description of Service/Supply and Fee/Cost were completed.

Upon Penalty of perjury, I Joselito C. SALAS (*print name*)
the PRESIDENT/CEO (*title*) and duly authorized representative
of the MBE Firm (MBE/WBE *firm*) affirm

that the foregoing information is true and correct and the services, supplies, and/or project indicated above will be supplies/performed for the above indicated total dollar amount $ 586,140.77 which represents the above indicated total percentage 10 % for the contract amount $ 5,774,785.95.

(Signature of affiant) 5/24/2011 (Date)

Subscribed and sworn to before me this 24 day of May, 20 11

Jennifer M. Oliveri (Notary's Signature) (Notary Seal)

OFFICIAL SEAL
JENNIFER M OLIVERI
NOTARY PUBLIC - STATE OF ILLINOIS
MY COMMISSION EXPIRES:12/30/13

COOK COUNTY LETTER OF INTENT
FROM BIDDER OR PROPOSER TO COOK COUNTY

Upon penalty of perjury, Monica Billinger (print name),

the Manager Corporate Supplier Diversity (*title*) and duly authorized

representative of Health Care Service Corporation (*Bidder Proposer firm*),

affirm that the foregoing information is true and correct and the services, supplies, and/or project indicated above will

be supplied/performed for the above indicated total dollar amount $586,140.77, which represents the

above indicated total percentage 10 % for the contract amount $ 5,774,785.95.

Monica Billinger
(Signature of affiant)

5/26/11
(Date)

Subscribed and sworn to before me this 26th day of May, 2011.

Maria Zavala
(Notary's Signature)

(Notary Seal)
OFFICIAL SEAL
MARIA ZAVALA
NOTARY PUBLIC - STATE OF ILLINOIS
MY COMMISSION EXPIRES:03/18/12

04.09

COOK COUNTY LETTER OF INTENT
(Section 2)

FROM MBE/WBE TO PERFORM AS SUBCONTRACTOR, SUPPLIER AND/OR CONSULTANT

Contract Title & Number: Employer-Sponsor Health / 11-87-004Q (Health)

From: Terrance Electric Company & Technology Company
(MBE/WBE Firm)

To: Health Care Service Corporation and the County of Cook
(Bidder/Proposer Firm)

The Undersigned is prepared to provide the following services, supplies and project in connection with the above named contract (the "Contract"):

Each service performed and /or item supplied will be detailed under Description of Service/Supply and Project with all services/items totaled under Fee/Cost to equal the full dollar amount of the Letter of Intent ***All services performed and/or supplies provided must be directly related to this specific Cook County contract and must not include any services/supplies related to any other government contract.***

Description of Service/Supply/Project	Fee/Cost	
1 Electrical Supplies & Maintenance	$ 303,176.26	05 %
2.	$	%
3.	$	%
4	$	%
Total:	$ 303,176.26	05 %

THE UNDERSIGNED PARTIES AGREE that this Letter of Intent will become a binding Subcontract Agreement conditioned upon the Bidder/Proposer's receipt of a signed contract from the County of Cook. The Undersigned Parties do also certify that they did not affix their signatures to this document until all areas under Description of Service/Supply and Fee/Cost were completed

Upon Penalty of perjury. I Judy Shimkus *(print name)*

the Manager *(title)* and duly authorized representative

of the Terrance Electric & Technology Co. (MBE/WBE *firm)* affirm

that the foregoing information is true and correct and the services, supplies. and/or project indicated above will be

supplies/performed for the above indicated total dollar amount $ 303,176.26 which represents the

above indicated total percentage 05 % for the contract amount $ 5,774,785.95

Judy Shimkus
(Signature of affiant)

05 / 24 / 11
(Date)

Subscribed and sworn to before me this 24th day of May, 20 11

Erin Moore
(Notary's Signature)

(Notary Seal)

"OFFICIAL SEAL"
ERIN MOORE
NOTARY PUBLIC, STATE OF ILLINOIS
MY COMMISSION EXPIRES 6/13/2012

COOK COUNTY LETTER OF INTENT
FROM BIDDER OR PROPOSER TO COOK COUNTY

Upon penalty of perjury, Monica Billinger (print name),

the Manager Corporate Supplier Diversity (*title*) and duly authorized

representative of Health Care Service Corporation (*Bidder Proposer firm*),

affirm that the foregoing information is true and correct and the services, supplies, and/or project indicated above will

be supplied/performed for the above indicated total dollar amount $ 303,176.26, which represents the

above indicated total percentage 05 % for the contract amount $ 5,774,785.95.

Monica Billinger
(Signature of affiant)

5/26/11
(Date)

Subscribed and sworn to before me this 26th day of May, 2011.

Maria Zavala
(Notary's Signature)

OFFICIAL SEAL (Notary Seal)
MARIA ZAVALA
NOTARY PUBLIC - STATE OF ILLINOIS
MY COMMISSION EXPIRES:03/18/12

C. GOOD FAITH EFFORTS TO OBTAIN MBE/WBE PARTICIPATION

Bidder/Proposer shall check each item applicable to its reason for a waiver request. **Additionally, supporting documentation shall be submitted with this request. If such supporting documentation cannot be submitted with bid/proposal/quotation, such documentation shall be submitted directly to the Office of Contract Compliance no later than three (3) days from the date of submission date.**

☐ 1) Made timely written solicitation to identified MBEs and WBEs for utilization of goods and/or services; and provided MBEs and WBEs with a timely opportunity to review and obtain relevant specifications, terms and conditions of the proposal to enable MBEs and WBEs to prepare an informed response to solicitation **(please attach)**

☐ 2) Followed up initial solicitation of MBEs and WBEs to determine if firms are interested in doing business **(please attach)**

☐ 3) Advertised in a timely manner in one or more daily newspapers and/or trade publication for MBEs and WBEs for supply of goods and services **(please attach)**

☐ 4) Use the services and assistance of the Office of Contract Compliance Staff **(please explain)**

☒ 5) Engaged MBEs & WBEs for indirect participation **(please explain)**

As core medical services are administered in-house, Blue Cross and Blue Shield of Illinois (BCBSIL) engages minority and women-owned businesses for indirect participation. BCBSIL proactively identifies and include MBEs & WBEs as valued diverse subcontractors in its supply chain. We believe our trusted diverse subcontractors play a vital role in delivering quality, affordable health care to our members.

For several years, Corporate Supplier Diversity has reported monthly in-direct expenditures with minority and women-owned businesses to Ms. Sharla Roberts, Compliance Officer, Contract Compliance at Cook County. We would be happy to provide copies of the Status Report of MBE/WBE (Sub) Contractor Payments for contract no. #07-41-229 at any time.

D. OTHER RELEVANT INFORMATION

Attach any other documentation relative to Good Faith Efforts in complying with MBE/WBE participation.

CERTIFICATIONS
(SECTION 4)

THE FOLLOWING CERTIFICATIONS ARE MADE PURSUANT TO STATE LAW AND THE CODE. THE UNDERSIGNED IS CAUTIONED TO CAREFULLY READ THESE CERTIFICATIONS PRIOR TO SIGNING THE SIGNATURE PAGE. SIGNING THE SIGNATURE PAGE SHALL CONSTITUTE A WARRANTY BY THE UNDERSIGNED THAT ALL THE STATEMENTS, CERTIFICATIONS AND INFORMATION SET FORTH WITHIN THESE CERTIFICATIONS ARE TRUE, COMPLETE AND CORRECT AS OF THE DATE THE SIGNATURE PAGE IS SIGNED. THE UNDERSIGNED IS NOTIFIED THAT IF THE COUNTY LEARNS THAT ANY OF THE FOLLOWING CERTIFICATIONS WERE FALSELY MADE, THAT ANY CONTRACT ENTERED INTO WITH THE UNDERSIGNED SHALL BE SUBJECT TO TERMINATION.

A. PERSONS AND ENTITIES SUBJECT TO DISQUALIFICATION

No person or business entity shall be awarded a contract or sub-contract, for a period of five (5) years from the date of conviction or entry of a plea or admission of guilt, civil or criminal, if that person or business entity:

1) Has been convicted of an act committed, within the State of Illinois, of bribery or attempting to bribe an officer or employee of a unit of state, federal or local government or school district in the State of Illinois in that officer's or employee's official capacity;

2) Has been convicted by federal, state or local government of an act of bid-rigging or attempting to rig bids as defined in the Sherman Anti-Trust Act and Clayton Act. Act. 15 U.S.C. Section 1 *et seq.;*

3) Has been convicted of bid-rigging or attempting to rig bids under the laws of federal, state or local government;

4) Has been convicted of an act committed, within the State, of price-fixing or attempting to fix prices as defined by the Sherman Anti-Trust Act and the Clayton Act. 15 U.S.C. Section 1, *et seq.;*

5) Has been convicted of price-fixing or attempting to fix prices under the laws the State;

6) Has been convicted of defrauding or attempting to defraud any unit of state or local government or school district within the State of Illinois;

7) Has made an admission of guilt of such conduct as set forth in subsections (1) through (6) above which admission is a matter of record, whether or not such person or business entity was subject to prosecution for the offense or offenses admitted to; or

8) Has entered a plea of *nolo contendere* to charge of bribery, price-fixing, bid-rigging, or fraud, as set forth in sub-paragraphs (1) through (6) above.

In the case of bribery or attempting to bribe, a business entity may not be awarded a contract if an official, agent or employee of such business entity committed the Prohibited Act on behalf of the business entity and pursuant to the direction or authorization of an officer, director or other responsible official of the business entity, and such Prohibited Act occurred within three years prior to the award of the contract. In addition, a business entity shall be disqualified if an owner, partner or shareholder controlling, directly or indirectly, 20 % or more of the business entity, or an officer of the business entity has performed any Prohibited Act within five years prior to the award of the Contract.

THE UNDERSIGNED HEREBY CERTIFIES THAT: The Undersigned has read the provisions of Section A, Persons and Entities Subject to Disqualification, that the Undersigned has not committed any Prohibited Act set forth in Section A, and that award of the Contract to the Undersigned would not violate the provisions of such Section or of the Code.

B. BID-RIGGING OR BID ROTATING

THE UNDERSIGNED HEREBY CERTIFIES THAT: *In accordance with 720 ILCS 5/33 E-11, neither the Undersigned nor any Affiliated Entity is barred from award of this Contract as a result of a conviction for the violation of State laws prohibiting bid-rigging or bid rotating.*

C. **DRUG FREE WORKPLACE ACT**

THE UNDERSIGNED HEREBY CERTIFIES THAT: The Undersigned will provide a drug free workplace, as required by Public Act 86-1459 (30 ILCS 580/2-11).

D. **DELINQUENCY IN PAYMENT OF TAXES**

THE UNDERSIGNED HEREBY CERTIFIES THAT: *The Undersigned is not an owner or a party responsible for the payment of any tax or fee administered by Cook County, by a local municipality, or by the Illinois Department of Revenue, which such tax or fee is delinquent, such as bar award of a contract or subcontract pursuant to the Code, Chapter 34, Section 34-129.*

E. **HUMAN RIGHTS ORDINANCE**

No person who is a party to a contract with Cook County ("County") shall engage in unlawful discrimination or sexual harassment against any individual in the terms or conditions of employment, credit, public accommodations, housing, or provision of County facilities, services or programs (Code Chapter 42, Section 42-30 *et seq*).

F. **ILLINOIS HUMAN RIGHTS ACT**

THE UNDERSIGNED HEREBY CERTIFIES THAT: *It is in compliance with the the Illinois Human Rights Act (775 ILCS 5/2-105), and agrees to abide by the requirements of the Act as part of its contractual obligations.*

G. **MACBRIDE PRINCIPLES, CODE CHAPTER 34, SECTION 34-132**

If the primary contractor currently conducts business operations in Northern Ireland, or will conduct business during the projected duration of a County contract, the primary contractor shall make all reasonable and good faith efforts to conduct any such business operations in Northern Ireland in accordance with the MacBride Principles for Northern Ireland as defined in Illinois Public Act 85-1390.

H. **LIVING WAGE ORDINANCE PREFERENCE (COOK COUNTY CODE, CHAPTER 34, SECTION 34-127;**

The Code requires that a living wage must be paid to individuals employed by a Contractor which has a County Contract and by all subcontractors of such Contractor under a County Contract, throughout the duration of such County Contract. The amount of such living wage is determined from time to time by, and is available from, the Chief Financial Officer of the County.

For purposes of this EDS Section 4, H, "Contract" means any written agreement whereby the County is committed to or does expend funds in connection with the agreement or subcontract thereof. The term "Contract" as used in this EDS, Section 4, I, specifically excludes contracts with the following:

1) Not-For Profit Organizations (defined as a corporation having tax exempt status under Section 501(C)(3) of the United State Internal Revenue Code and recognized under the Illinois State not-for -profit law);

2) Community Development Block Grants;

3) President's Office of Employment Training;

4) Sheriff's Work Alternative Program; and

5) Department of Correction inmates.

REQUIRED DISCLOSURES
(SECTION 5)

1. DISCLOSURE OF LOBBYIST CONTACTS

List all persons or entities that have made lobbying contacts on your behalf with respect to this contract:

Name Address

_____

_____

_____

2. LOCAL BUSINESS PREFERENCE DISCLOSURE; CODE, CHAPTER 34, SECTION 34-151(p);

"Local Business" shall mean a person authorized to transact business in this State and having a bona fide establishment for transacting business located within Cook County at which it was actually transacting business on the date when any competitive solicitation for a public contract is first advertised or announced and further which employs the majority of its regular, full time work force within Cook County, including a foreign corporation duly authorized to transact business in this State and which has a bona fide establishment for transacting business located within Cook County at which it was actually transacting business on the date when any competitive solicitation for a public contract is first advertised or announced and further which employs the majority of its regular, full time work force within Cook County.

a) Is Bidder a "Local Business" as defined above?

Yes:_____ No:_____

b) If yes, list business address(es) within Cook County:

_____

_____

_____

c) Does Bidder employ the majority of its regular full-time workforce within Cook County?

Yes:_____ No:_____

3. THE CHILD SUPPORT ENFORCEMENT ORDINANCE (PREFERENCE (CODE, CHAPTER 34, SECTION 34-366)

Every Applicant for a County Privilege shall be in full compliance with any child support order before such Applicant is entitled to receive or renew a County Privilege. When delinquent child support exists, the County shall not issue or renew any County Privilege, and may revoke any County Privilege. All Applicants are required to review the Cook County Affidavit of Child Support Obligations attached to this EDS **and** complete the following, based upon the definitions and other information included in such Affidavit:

_____ Applicant has no "Substantial Owner."

OR

_____ The Cook County Affidavit of Child Support Obligations has been completed by all "Substantial Owners" and is attached to this EDS.

4. **REAL ESTATE OWNERSHIP DISCLOSURES.**

The Undersigned must indicate by checking the appropriate provision below and providing all required information that either:

a) The following is a complete list of all real estate owned by the Undersigned in Cook County:

PERMANENT INDEX NUMBER(S): 36-12366 10

_____

_____

(ATTACH SHEET IF NECESSARY TO LIST ADDITIONAL INDEX NUMBERS)

OR:

b) _____The Undersigned owns no real estate in Cook County.

5. **EXCEPTIONS TO CERTIFICATIONS OR DISCLOSURES.**

If the Undersigned is unable to certify to any of the Certifications or any other statements contained in this EDS and not explained elsewhere in this EDS, the Undersigned must explain below:

_____

_____

If the letters, "NA", the word "None" or "No Response" appears above, or if the space is left blank, it will be conclusively presumed that the Undersigned certified to all Certifications and other statements contained in this EDS.

COOK COUNTY AFFIDAVIT OF CHILD SUPPORT OBLIGATIONS

Effective July 1, 1998, every applicant for a County Privilege shall be in full compliance with any Child Support Order before such applicant is entitled to receive a County Privilege. When Delinquent Child Support Exists, the County shall not issue or renew any County Privilege, and may revoke any County Privilege.

"*Applicant*" means any person or business entity, including all Substantial Owners, seeking issuance of a County Privilege or renewal of an existing County Privilege from the County. This term shall not include any political subdivision of the federal or state government, including units of local government, and not-for-profit organizations.

"*County Privilege*" means any business license, including but not limited to liquor dealers' licenses, packaged goods licenses, tavern licenses, restaurant licenses, and gun licenses; real property license or lease; permit, including but not limited to building permits, zoning permits or approvals; environmental certificate; County HOME Loan, and contracts exceeding the value of $10,000.00.

"*Substantial Owner*" means any person or persons who own or hold a twenty-five\ percent (25%) or more percentage of interest in any business entity seeking a County Privilege, including those shareholders, general or limited partners, beneficiaries and principals; except where a business entity is an individual or sole proprietorship, Substantial Owner means that individual or sole proprietor.

All Applicants/Substantial Owners are required to complete this affidavit and comply with the Child Support Enforcement Ordinance before any privilege is granted. Signature of this form constitutes a certification the information provided below is correct and complete, and that the individual(s) signing this form has/have personal knowledge of such information.

Privilege Information:

County Privilege: _____

County Department: _____

Applicant Information:

Last name: _____ First Name: _____ MI: _____

SS# (Last Four Digits): ____ ____ ____ ____

Street Address: _____

City: _____ State: _____ Zip: _____

Home Phone: (___) _____ - _____ Drivers License No: _____

Child Support Obligation Information:

The Undersigned applicant, being duly sworn on oath or affirmation hereby states that to the best of my knowledge (place an "X" next to "A" "B", "C", or "D")

_____ A. The Applicant has no judicially or administratively ordered child support obligations.

_____ B. The Applicant has an outstanding judicially or administratively ordered obligation, but is paying in accordance with the terms of the order.

_____ C. The Applicant is delinquent in paying judicially or administratively ordered child support obligations

__X__ D. The Applicant is not a substantial owner as defined above.

The Undersigned applicant understands that failure to disclose any judicially or administratively ordered child support debt owed will be grounds for revoking the privilege.

Signature: [illegible] Date: 5/23/11

Subscribed and sworn to before me this 23 day of May, 20 11

X Sylvia Fraga

Notary Public Signature

Notary Seal

OFFICIAL SEAL
SYLVIA FRAGA
NOTARY PUBLIC - STATE OF ILLINOIS
MY COMMISSION EXPIRES:03/01/12

COOK COUNTY DISCLOSURE OF OWNERSHIP INTEREST STATEMENT

The Cook County Code of Ordinances (§2-610 *et seq.*) requires that any Applicant for any County Action must disclose information concerning ownership interests in the Applicant. This Disclosure of Ownership Interest Statement must be completed with all information current as of the date this Statement is signed. Furthermore, this Statement must be kept current, by filing an amended Statement, until such time as the County Board or County Agency shall take action on the application. The information contained in this Statement will be maintained in a database and made available for public viewing.

If you are asked to list names, but there are no applicable names to list, you must state NONE. An incomplete Statement will be returned and any action regarding this contract will be delayed. A failure to fully comply with the ordinance may result in the action taken by the County Board or County Agency being voided.

"*Applicant*" means any Entity or person making an application to the County for any County Action.

"County Action" means any action by a County Agency, a County Department, or the County Board regarding an ordinance or ordinance amendment, a County Board approval, or other County agency approval, with respect to contracts, leases, or sale or purchase of real estate.

"Entity" or *"Legal Entity"* means a sole proprietorship, corporation, partnership, association, business trust, estate, two or more persons having a joint or common interest, trustee of a land trust, other commercial or legal entity or any beneficiary or beneficiaries thereof.

This Disclosure of Ownership Interest Statement must be submitted by :

1. An Applicant for County Action and

2. An individual or Legal Entity that holds stock or a beneficial interest in the Applicant and is listed on the Applicant's Statement (a "Holder") must file a Statement and complete #1 only under **Ownership Interest Declaration**.

Please print or type responses clearly and legibly. Add additional pages if needed, being careful to identify each portion of the form to which each additional page refers.

This Statement is being made by the [ ] Applicant or [ ] Stock/Beneficial Interest Holder

This Statement is an: [X] Original Statement or [ ] Amended Statement

Identifying Information:

Name: Health Care Service Corporation D/B/A: Blue Cross Blue Shield of IL EIN NO.: 36-1236610

Street Address: 300 E. Randolph St.

City: Chicago State: Illinois Zip Code: 60601

Phone No.: 312-653-6000

Form of Legal Entity:

[ ] Sole Proprietor [ ] Partnership [X] Corporation [ ] Trustee of Land Trust

[ ] Business Trust [ ] Estate [ ] Association [ ] Joint Venture

[ ] Other (describe) _____

Ownership Interest Declaration:

1. List the name(s), address, and percent ownership of each individual and each Entity having a legal or beneficial interest (including ownership) of more than five percent (5%) in the Applicant/Holder.

Name	Address	Percentage Interest in Applicant/Holder
BCBSIL is a division of Health Care Service Corporation (HCSC) which is a mutual legal reserve company, wholly owned by our policyholders. There is no one individual or group of individuals that own a percentage of HCSC.		

2. If the interest of any individual or any Entity listed in (1) above is held as an agent or agents, or a nominee or nominees, list the name and address of the principal on whose behalf the interest is held.

Name of Agent/Nominee	Name of Principal	Principal's Address
This is not applicable.		

3. Is the Applicant constructively controlled by another person or Legal Entity? [ ] Yes [X] No

If yes, state the name, address and percentage of beneficial interest of such person or legal entity, and the relationship under which such control is being or may be exercised.

Name	Address	Percentage of Beneficial Interest	Relationship
This is not applicable.			

Declaration (check the applicable box):

[ ] I state under oath that the Applicant has withheld no disclosure as to ownership interest in the Applicant nor eserved any information, data or plan as to the intended use or purpose for which the Applicant seeks County Board or other County Agency action.

[X] I state under oath that the Holder has withheld no disclosure as to ownership interest nor reserved any information required to be disclosed.

Richard Allegretti
Name of Authorized Applicant/Holder Representative (please print or type)

VP of Local & State Markets
Title

Signature

November 21, 2011
Date

allegrettir@bcbsil.com
E-mail address

312-653-5727
Phone Number

Subscribed to and sworn before me
this 21 day of November 2011.

X Sylvia Fraga
Notary Public Signature

My commission expires:

OFFICIAL SEAL
SYLVIA FRAGA
NOTARY PUBLIC - STATE OF ILLINOIS
MY COMMISSION EXPIRES 8/30/12

SIGNATURE BY A CORPORATION
(SECTION 8)

The Undersigned hereby certifies and warrants: that all of the statements, certifications, and representations set forth in this EDS are true, complete and correct; that the Undersigned is in full compliance and will continue to be in compliance throughout the term of the Contract or County Privilege issued to the Undersigned with all the policies and requirements set forth in this EDS; and that all of the facts and information provided by the Undersigned in this EDS are true, complete and correct. The Undersigned agrees to inform the Purchasing Agent in writing if any of such statements, certifications, representations, facts or information becomes or is found to be untrue, incomplete or incorrect during the term of the Contract or County Privilege.

BUSINESS NAME: Health Care Service Corporation, a Mutual Legal Reserve Company operating through its Blue Cross and Blue Shield of Illinois division

BUSINESS ADDRESS: 300 E. Randolph St., Chicago, IL 60601

BUSINESS TELEPHONE: 312.653.7169 FAX NUMBER: 312.228.7810

CONTACT PERSON: Sandra Gonzalez

FEIN: 36-1236610 *IL CORPORATE FILE NUMBER:

LIST THE FOLLOWING CORPORATE OFFICERS:

PRESIDENT: Karen Atwood VICE PRESIDENT: Martin G. Foster

SECRETARY: Deborah Dorman-Rodriguez TREASURER: Gerald T. Mallen

**SIGNATURE OF PRESIDENT: Karen M. Atwood

ATTEST: _____ (CORPORATE SECRETARY)

OFFICIAL SEAL
CAROL L ABEL
NOTARY PUBLIC - STATE OF ILLINOIS
MY COMMISSION EXPIRES:06/22/15

Subscribed and sworn to before me this

15 day of November, 20 11.

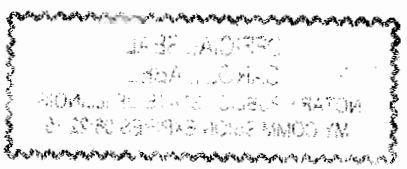
My commission expires:

X Carol L Abel
Notary Public Signature

6/22/15
Notary Seal

* **If the corporation is not registered in the State of Illinois, a copy of the Certificate of Good Standing from the state of incorporation must be submitted with this Signature Page.**

** **In the event that this Signature Page is signed by any persons than the President and Secretary, attach either a certified copy of the corporate by-laws, resolution or other authorization by the corporation, authorizing such persons to sign the Signature Page on behalf of the corporation.**



COOK COUNTY SIGNATURE PAGE
(SECTION 9)

ON BEHALF OF THE COUNTY OF COOK, A BODY POLITIC AND CORPORATE OF THE STATE OF ILLINOIS, THIS CONTRACT IS HEREBY EXECUTED BY:

Toni Preckwinkle
PRESIDENT, COOK COUNTY BOARD OF COMMISSIONERS

Maria de Lourdes Cox
COOK COUNTY PURCHASING AGENT

Robert Renbold
COOK COUNTY COMPTROLLER

DATED AT CHICAGO, ILLINOIS THIS 18th DAY OF January, 2012.

IN THE CASE OF A BID PROPOSAL, THE COUNTY HEREBY ACCEPTS:

THE FOREGOING BID/PROPOSAL AS IDENTIFIED IN THE CONTRACT DOCUMENTS FOR CONTRACT NUMBER

_____

OR

APPROVED BY BOARD OF
COOK COUNTY COMMISSIONERS

ITEM(S), SECTION(S), PART(S): _____

JAN 18 2012

_____ COM _____

TOTAL AMOUNT OF CONTRACT: $ 262,000,000.00
(DOLLARS AND CENTS)

FUND CHARGEABLE: 542-176 (Health Insurance)

APPROVED AS TO FORM:

Randy M
ASSISTANT STATE'S ATTORNEY

EXHIBIT 1

Scope of Services

Scope of Services includes the following Attachments

Attachment 1 – Transition Allowances
Attachment 2 – Performance Guarantees
Attachment 3 – BCBS Health Care Benefit Program Certificate of Coverage

Scope of Services

Function		Standard Services	Confirm
Billing/Fees/ Premium Collection	1.	Vendor agrees to invoice the County for claims payments and for administrative services on a monthly basis.	Yes - In Base Fee
	2.	The County will pay for premiums (if fully insured) or claim payments/administration fees (if self-funded) via checks monthly with a 60 days drag.	Yes - In Base Fee
Claims Administration Services	3.	Identification of upcoded, unbundled and/or fragmented claim submissions.	Yes - In Base Fee
	4.	Initial overpayment recovery effort including referral to outside collection agency.	Yes - In Base Fee
	5.	Maintenance of Plan and Member information for claim calculation.	Yes - In Base Fee
	6.	Fraud Prevention Programs	Yes - In Base Fee
	7.	Application of R & C limits for physician claims for Indemnity, in-network non-contracted providers, and out-of-network claims.	Yes - In Base Fee
	8.	Application of negotiated fees with providers for in-network portion of plan designs.	Yes - In Base Fee
	9.	Toll-free line for Cook County member calls to claims office.	Yes - In Base Fee
	10.	Handle disbursement of funds for the New York Health Care Reform Act.	Yes - In Base Fee
	11.	Investigate claims and discuss claims with health providers when necessary.	Yes - In Base Fee
	12.	Respond to Insurance Department complaints.	Yes - In Base Fee
	13.	Notification to Members of denied Plan Benefit claims, the reason for the denial and appeal rights.	Yes - In Base Fee
	14.	Evaluate and process claims.	Yes - In Base Fee
	15.	Administration of subrogation/conditional claim payment.	Yes - In Base Fee
	16.	On a monthly basis, perform at least 3% internal audits of Plan benefit payments on a random sample basis (manual and auto-adjudicated claims).	Yes - In Base Fee
	17.	Outpatient radiology and pathology claims paid as in network after claim history is scanned for in network office visits.	Yes - In Base Fee
	18.	All anesthesia and assistant surgeon services paid in network (assuming related care is in-network).	Yes - In Base Fee
	19.	Claim adjudication based on plan design.	Yes - In Base Fee
	20.	Coordination of benefits (Medicare or other)	Yes - In Base Fee
	21.	Dedicated customer and claims service units for Cook County with electronic access to eligibility, claims history from all adjudication systems.	Yes - In Base Fee

Scope of Services

	22.	Vendor will take and complete corrective action within 30 days of audit that shows any discrepancy. If action requires additional training, corrective action should be completed within 60 days.	Yes - In Base Fee
	23.	Maximum reimbursable charge determinations.	Yes - In Base Fee
	24.	Delivery of necessary information regarding standard application of non-duplication or coordination of benefits.	Yes - In Base Fee
	25.	Review of medical bills.	Yes - In Base Fee
Drafting	26.	Preparing administrative services contract, agreements and other related agreements/amendments	Yes - In Base Fee
	27.	Review Plan Sponsor documents from Cook County and produce final plan documents in a timely manner.	Yes - In Base Fee
	28.	Prepare Summary Plan Description (SPDs)	Yes - In Base Fee
	29.	Assist Cook County with member communications as required.	Yes - In Base Fee
	30.	Provide communications and production support to develop, modify, produce and print materials (e.g. preventive care flyers).	Yes - In Base Fee
	31.	Cook County must be allowed to review key member communication in advance of distribution, regardless of distribution method.	Yes - In Base Fee
Eligibility	32.	Eligibility verification using weekly Member eligibility data feed updated weekly by the County.	Yes - In Base Fee
	33.	Notification confirming eligibility file was received and processed; error reports sent electronically via secure email or accessible via a secure website, with notification that error reports are ready for review within a week of receiving the file	Yes - In Base Fee
	33.	Minimum of once weekly Eligibility File Submission to be sent to PBM (CVS Caremark currently) for Cook County	Yes - In Base Fee
Enrollment	34.	Work with the County to develop Open Enrollment materials (funded and produced by the vendor - approximately $60,000 per year).	Yes - In Base Fee
Plan Changes	35.	Cook County reserves right to terminate agreement if parties cannot come to agreement on new service fee due to plan changes within 30 days of Cook County's receipt of vendor's request for change in service fee.	Yes - In Base Fee
	36.	Cook County has right to continue plan for 30 days after above deadline before terminating agreement.	Yes - In Base Fee
Service Support	37.	Cohesive and dedicated Account Management team available to Cook County including account executive, clinical account manager with a clinical focus and background (RN, at minimum), financial/analytic consultant to assist with development and performance of ad-hoc and regular reporting services as well as fully integrated claim and account management teams.	Yes - In Base Fee
	38.	Dedicated customer advocate that will serve as a direct contact and resource to Cook County Benefits Staff and members to answer questions and escalate issues. Advocate would be located at the claim and customer service site.	Yes - In Base Fee
	39.	Provide information relating to Plan and Services within 30 days, or less if mutually agreed upon or required by law.	Yes - In Base Fee
	40.	Provide Cook County with a de-identified summary of issues from issue tracking database upon request.	Yes - In Base Fee

Scope of Services

	41.	On-site Open Enrollment meetings (approx. 15 meetings per year)	Yes - In Base Fee
	42.	On-site quarterly meetings, as requested.	Yes - In Base Fee
	43.	No additional administrative charges for ad hoc reports, special processes, communication materials, etc.	Yes - In Base Fee
	44.	Annual paper and electronic based member satisfaction surveys, ongoing member service callback surveys and annual account/implementation satisfaction surveys	Yes - Included in Base
Financial Underwriting	45.	Prepare and communicate annual accounting package reconciling the number of claims, administrative fees, and claims paid vs. actual charges.	Yes - In Base Fee
	45.	Provide current and projected costs including quotations for alternate benefits and/or levels of administrative services.	Yes - In Base Fee
	45.	Provide Cook County and their consultants direct access to your underwriters.	Yes - In Base Fee
	46.	Prepare and communicate renewal fees	Yes - In Base Fee
	47.	Support Field/Account Executives with ad hoc issues management	Yes - Included in Base
ID Cards	48.	Use Alternate ID numbers not generated by Cook County for member identification.	Yes - In Base Fee
	49.	Cook County's name/logo will be displayed on ID card.	Yes - In Base Fee
	50.	Customize ID cards to meet Cook County's specification (as requested).	Yes - In Base Fee
	51.	Online access available to members to request cards	Yes - In Base Fee
	52.	ID cards distributed to each member of a family within 5 business days from the request.	Yes - Included in Base
Member Services	53.	Toll-free line with member services team that will answer participant calls from 8:00 AM - 8:00 PM CST, Monday through Friday (except Federal holidays).	Yes - Included in Base
	54.	Dedicated member services team that will respond to telephone, electronic mail and written inquiries from participants. The team will also document all inquiries in secure issue tracking database.	Yes - Included in Base
	55.	Access to in-network physician/office locator via Internet and via paper directory, upon request.	Yes - Included in Base
	56.	Member access to EOBs online and ability to select paperless option.	Yes - Included in Base
	57.	Respond to and document employee first and second level ERISA appeals, complaints and grievances	Yes - Included in Base
	58.	Customized client-specific website with personal benefits, claims information, and consumer decision support tools and services for performing common transactions.	Yes - Included in Base
	59.	Distribution of drafts, standard EOBs and explanation of provider payments (EPPs).	Yes - Included in Base

Scope of Services

	60.	Respond to members request for access to, amendment and accounting of PHI and requests for restriction and alternative communications as required under HIPAA law and regulations.	Yes - Included in Base
Patient Management Services	61.	Precertification of inpatient stays	Yes - Included in Base
	62.	Concurrent review/discharge planning	Yes - Included in Base
	63.	Care coordination	Yes - Included in Base
	64.	Centers of Excellence program for transplants and rare or complex conditions	Yes - Included in Base
Data/Reporting	65.	Standard claim and funding reports and mediums on a monthly basis (provide samples)	Yes - Included in Base
	66.	Semi-annual report of Jan - June and July - Dec claims (used for annual 5500 reporting audit)	Yes - Included in Base
	67.	Schedule A-type document for 5500 reporting	Yes - Included in Base
	68.	Online access to experience reports and ad-hoc reporting tools capable of reporting at Business Area and Sub-Area level of detail as defined by Cook County.	Yes - Included in Base
	69.	Provide regular and ad hoc reports covering claim detail, medical utilization and trends, subrogation, operational activity, etc.	Yes - Included in Base
	70.	Custom reporting (specify hours included in base fee)	Yes - Included in Base
	71.	Facilitate data exchanges required for the County's COBRA administration (in-house)	Yes - Included in Base
	72.	Respond to CMS research requests such as Medicare Secondary Payor requests.	Yes - Included in Base
	73.	No data input services provided off shore.	Yes - Included in Base
	74.	Limit data fields transferred to only the essential elements that are necessary for managing Cook County's benefit plans.	Yes - Included in Base
	75.	Type 2 SAS 70 audit report delivered to Cook County annually.	Yes - Included in Base
Implementation	76.	Comprehensive systems testing and quality assurance audits, with results reported to Cook County, prior to the contract effective date.	Yes - Included in Base
	77.	Develop formal implementation plan which defines key tasks, dependencies and completion dates and is agreed to by both parties	Yes - Included in Base
	78.	Develop a specific transition policy for participants who are in the middle of care and their provider is no longer in-network.	Yes - Included in Base
	79.	Vendor agrees that the dedicated implementation manager will continue to support Cook County a minimum of 45 days after the implementation date.	Yes - Included in Base

Scope of Services

	80.	Onsite training for the online reporting tool and offer a minimum of five user ID's	Yes - Included in Base
Networks	81.	Timely notification of provider terminations provided to Cook County with detailed member impact (minimum 45 days prior to termination).	Yes - Included in Base
	82.	Provide or arrange access to the applicable network of Participating Providers to furnish health care services/products to Members at negotiated rates and methods of reimbursement.	Yes - Included in Base
	83.	Credential and re-credential Participating Providers and ensure third-party network vendors credential/re-credential Participating providers in accordance with your standard vendor requirements.	Yes - Included in Base
	84.	Review Participating Provider compliance with protocols and procedures for quality, participant satisfaction, and grievance resolution	Yes - Included in Base
	85.	Facilitate the identification of Participating Providers by Members.	Yes - Included in Base

SCOPE OF SERVICES

Transition Allowances

Category	Proposed Allowance	Confirm	Comment
Audits			
Pre-Implementation Audit		No	Not applicable as incumbant carrier.
Post-Implementation Audit (within three months of go-live)		No	Not applicable as incumbant carrier.
Due Diligence Audit (within one year of go-live)		No	Not applicable as incumbant carrier.
Ongoing Audits (if vendor fails)		No	Not applicable as incumbant carrier.
Other			
Other Implementation Allowance		No	Not applicable as incumbant carrier.
Biometric/Health Screenings		Yes	Allowance of $75,000
Communications Materials		Yes	Allowance of $75,000
Total $ Amount - Transition Cost Allowances		Yes	Total Allowance of $150,000
Other Allowance		Choose Response	
Other Allowance		Choose Response	
Other Allowance		Choose Response	
Other Allowance		Choose Response	

PERFORMANCE GUARANTEES
EMPLOYER NAME: Cook County
Employer Group Number(s): 089801 and 289801
Effective for the Settlement Period beginning 12/1/11 and ending 11/30/2012

The Health Plan reserves the right to revise this Exhibit-PG in the event the enrollment in the medical plan varies by 10% or more over a one (1) year period, or 25% or more over a three (3) month period, from the enrollment on the Effective Date of December 1, 2011.
Performance measurement will begin December 1, 2011.

SERVICE - Medical	Defined Performance Guarantees	Performance Guarantee	Percentage of the Administrative Charge at Risk
Implementation	**Implementation Satisfaction** - Claim Administrator will complete the account implementation to the Employer's satisfaction. Claim Administrator's performance will be evaluated by the Employer based on results of the Claim Administrator Implementation Report Card to be determined based on implementation meetings.	Composite Score 3.0 - 5.0 0 - 2.9	 0% 2%
Claims Processing Turnaround Time – Process-Ready Claims	**Claims Processing Turnaround Time** means the period beginning on the date the Health Plan or Host Blue receives a Claim for processing through the date the Claim passes all system edits and benefits are approved or denied by the Health Plan. The performance guarantee is measured as a percent of process-ready Claims processed within 14 calendar days. Method of Measurement: The number of process-ready claims processed in 14 calendar days divided by the total number of process-ready claims. Process-ready means a Claim that, when received by the Health Plan, contains all of the Claim information required to process the Claim. Measurement is based on all Claims processed for those customers assigned to the Unit.	90.0% - 100% 88.0% - 89.9% 0% - 87.9%	0% 1% 2%
Claims Processing Turnaround Time – All Claims	**Claims Processing Turnaround Time** means the period beginning on the date the Health Plan or Host Blue Plan receives a Claim for processing through the date the Claim passes all system edits and benefits are approved or denied by the Health Plan. The performance guarantee is measured as a percent of all Claims processed within 30 calendar days. Method of Measurement: The number of Claims processed in 30 calendar days divided by the total number of claims. Measurement is based on all Claims processed for those customers assigned to the Unit.	98.0% - 100% 0% - 97.9%	0% 2%
Claim Processing Accuracy	**Claim Processing Accuracy** is defined as the percent of Claims processed accurately in accordance with the provisions of the medical benefit coverage administered by the Health Plan. Claim Processing Accuracy refers to Claims without processing errors such as:	97.0% - 100% 95.0% - 96.9% 0% - 94.9%	0% 1% 2%

SERVICE - Medical	Defined Performance Guarantees	Performance Guarantee	Percentage of the Administrative Charge at Risk
	1. Coding - incorrect claim data entry. 2. Failure to adhere to the Employer's health care benefit program design. 3. Failure to adhere to the administrative procedures. 4. System generated errors, benefit programming errors, calculation errors. 5. Excluding: a. Any administrative inaccuracies that do not impact claims disposition or customer reporting; b. Errors entered by providers of service; c. Benefits provided to an ineligible claimant due to the Employer's failure to provide timely and accurate eligibility information to the Health Plan. Method of measurement: The accuracy rate is determined from a statistically valid random stratified sample audit of all Claims processed during the settlement period. A Claim Processing Accuracy percentage is calculated for each stratum by dividing the number of accurately processed Claims by the number of Claims selected in the stratum. Each accuracy percentage is then weighted according to the total claim population. The Claim Processing Accuracy rate is determined by summing the weighted accuracy from each stratum. Measurement is based on an audit of Employer-specific Claims.		
Claim Financial Accuracy	**Claim Financial Accuracy** means the percent of dollars paid accurately in accordance with the provisions of the medical benefit coverage administered by the Health Plan. Method of measurement: The accuracy rate is determined from a statistically random stratified sample audit of all Claims paid during the Settlement Period. Total dollars overpaid and total dollars underpaid are projected over each stratum. Claim Financial Accuracy is computed by summing the projected overpayments and the projected underpayments (*absolute value*) from each stratum and dividing by the total dollars paid in the population. The end result is subtracted from one for the accuracy rate. Measurement is based on an audit of Employer-specific Claims.	99.0% - 100% 97.0% - 98.9% 0% - 96.9	0% 1% 2%
Claim Payment Accuracy	**Claim Payment Accuracy** means the percent of claims paid without over or under payments in accordance with the provisions of the medical benefit coverage administered by the Claim Administrator. Method of measurement: The accuracy rate is determined from a statistically valid random stratified sample audit of all Claims processed during the settlement period. A Claim Payment Accuracy percentage is calculated for each stratum by dividing the number of accurately paid Claims by the number of Claims selected in the stratum. Each accuracy	97.0% - 100% 95.0% - 96.9% 0% - 94.9%	0% 1% 2%

SERVICE - Medical	Defined Performance Guarantees	Performance Guarantee	Percentage of the Administrative Charge at Risk
	percentage is then weighted according to the total claim population. The Claim Payment Accuracy rate is determined by summing the weighted accuracy from each stratum. Measurement is based on an audit of Employer-specific Claims.		
Customer Service	**Average Speed of Answer of Telephone Calls,** calculated over the complete business day, is defined as the time a caller spends on hold until a Customer Advocate becomes available. Method of measurement: The average speed of answer will be calculated by dividing the total length of time for all calls, measured from the time a call is queued by the automated telephone system for the next available Customer Advocate until the time the caller is connected with a Customer Advocate, by the total number of calls connected with a Customer Advocate during the Settlement Period. The Average Speed to Answer is provided by telephone reports that compute the average number of seconds that Callers spend on hold waiting for their Call to be answered. Standard is measured using member calls from those customers assigned to the Unit.	0-30 seconds 31-35 seconds 36 seconds or more	0% 1% 2%
	Abandoned Calls are defined as calls, calculated over the complete business day, that reach the facility and are placed in a queue, but are not answered because the caller hangs up before a Customer Advocate becomes available. Any calls abandoned or terminated by the caller prior to 30 seconds will not be counted as Abandoned Calls. Standard is measured using member calls from those customers assigned to the Unit.	0%-3.0% 3.1%-5.0% 5.1%-100%	0% 1% 2%
	First Contact Closure is defined as the percent of calls closed on the same date as the date of the caller's initial contact. Standard is measured using participant calls from those customers assigned to the Unit.	80.0%-100% 79.0%-79.9% 0% - 78.9%	0% 1% 2%
	Outstanding Experience is defined from the member's perspective, as the percentage of time that the Customer Advocate showed the desire and the ability to address the member's questions. Method of measurement: Post Call Survey responses from those customers assigned to the Unit.	90% - 100% 89.0% - 89.9% 0% - 88.9%	0% 1% 2%
Total Medical			20%

MEDICAL MANAGEMENT	Defined Performance Guarantees Requirements: 1. Employer must provide a documented communication strategy prior to the beginning of the settlement period (At least 4 communications per year) and 2. Employer must offer incentives to members that support active engagement with clinical programs. Documentation of the incentives being offered must be provided during the proposal/renewal process. 3. At least 12 months of incurred claims and historical eligibility data must be available prior to the initial Settlement Period.	Performance Guarantee	Percentage of the BCC Administrative Charge at Risk
Participation	**Tobacco Cessation Program Participation** is defined as the percentage of targeted members who are actively engaged with a clinician. Actively engaged means the member or member's provider is participating in bi-directional communication with the Claim Administrator's designated clinician.	20% or more 10%-19.9% 0% - 9.9%	0% 2.5% 5.0%
	Weight Management Program Participation is defined as the percentage of targeted members who are actively engaged with a clinician. Actively engaged means the member or member's provider is participating in bi-directional communication with the Claim Administrator's designated clinician.	20% or more 10%-19.9% 0% - 9.9%	0% 2.5% 5.0%
	Core Condition Management Participation is defined as the percentage of targeted members identified with a health status of chronic or multi-chronic with one or more of the core conditions requiring **severe** condition management who are actively engaged with a clinician or are being managed through clinician-to-physician dialogue. Core conditions are Asthma, Diabetes, COPD, CAD, and CHF. Actively engaged means the member or member's provider is participating in bi-directional communication with the Claim Administrator's designated clinician. Note: "Core condition" definition and handling is subject to change in 2012. Appropriate communications will occur.	20% or more 10%-19.9% 0% - 9.9%	0% 5.0% 10.0%
	Intensified Case Management Participation is defined as the percentage of members who are identified as requiring outreach for an intensive level of intervention that are actively engaged and managed either Claim Administrator's clinician to member or clinician to member's provider. Actively engaged means the member or member's provider is participating in bi-directional communication with the Claim Administrator's designated clinician. The measurement(s) will exclude members who were identified as not appropriate for the program, have missing or invalid phone numbers, who drop coverage within 6 months after identification and who do not meet the readiness-to-change parameters for Lifestyle Management (Tobacco Cessation and Weight Management). The level of performance guarantee is based on results at the HCSC, or BCBSIL level.	20% or more 10%-19.9% 0% - 9.9%	0% 5.0% 10.0%
Total Medical Management			30.0%

SCOPE OF SERVICES

BLUE CROSS BLUE SHIELD
HEALTH CARE BENEFIT PROGRAM
CERTIFICATE OF COVERAGE

Your Health Care Benefit Program

Cook County Actives

089801

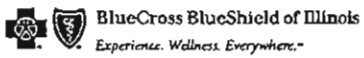
BlueCross BlueShield of Illinois

Experience. Wellness. Everywhere.℠

Your Health Care Benefit Program

Cook County Actives

089801



CERTIFICATE RIDER

(For Participating Provider Option Plans)

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

PHYSICIAN BENEFIT SECTION

The following Covered Service is added to the Physician Benefit Section of your Certificate:

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.

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)

Deborah Dorman-Rodriguez
Secretary

Patricia A. Hemingway Hall
President

GB-10-A164 HCSC

A message from

Cook County Actives

This booklet is your Certificate of Health Care Benefits. It describes the health 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 health care expenses.

Sincerely,

Cook County Actives

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

Patricia A. Hemingway Hall
President

Deborah Dorman-Rodriguez

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.

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.

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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®[1] 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
Lifetime Maximum for all Benefits	Unlimited
Individual Deductible	
— Participating Provider	None
— Non-Participating and Non-Plan Provider	$200 per benefit period
Family Deductible	
— Participating Provider	None
— Non-Participating and Non-Plan Provider	$400 per benefit period
Individual Out-of-Pocket Expense Limit **(does not apply to all services)**	
— Participating Provider	$1,000 per benefit period
— Non-Participating Provider	$3,000 per benefit period
— Non-Plan Provider	No limit
Family Out-of-Pocket Expense Limit	
— Participating Provider	$2,000 per benefit period
— Non-Participating Provider	$6,000 per benefit period
— Non-Plan Provider	No limit
Physical Therapy Services Benefit Maximum	60 visits per benefit period
Occupational Therapy Benefit Maximum	60 visits per benefit period
Speech Therapy Benefit Maximum	60 visits per benefit period

Additional Speech Therapy Benefits for Treatment of Pervasive Developmental Disorders	20 visits per benefit period

HOSPITAL BENEFITS

Payment level for Covered Services from a **Participating Provider:**	
— Inpatient Covered Services	90% of the Eligible Charge
— Outpatient Covered Services	90% of the Eligible Charge, no deductible
— Wellness Care	90% of the Eligible Charge
Payment level for Covered Services from a **Non-Participating Provider:**	
— Inpatient Covered Services	60% of the Eligible Charge
— Outpatient Covered Services	60% of the Eligible Charge
— Wellness Care	60% of the Eligible Charge
Payment level for Covered Services from a **Non-Plan Provider**	50% of the Eligible Charge
Hospital Emergency Care	
— Payment level for Emergency Accident Care from either a Participating, Non-Participating or Non-Plan Provider	100% of the Eligible Charge, no deductible
— Payment level for Emergency Medical Care from either a Participating, Non-Participating or Non-Plan Provider	100% of the Eligible Charge, no deductible

PHYSICIAN BENEFITS

Payment level for Surgical/ Medical Covered Services	
— **Participating Provider**	90% of the Maximum Allowance
— **Non-Participating Provider**	60% of the Maximum Allowance, no deductible

Payment level for Physician Office Visits	
— Participating Provider	$20 per visit, then 100% of the Maximum Allowance, no deductible
Payment level for Emergency Accident Care	100% of the Maximum Allowance, no deductible
— Physician office Copayment	$20 per visit
Payment level for Emergency Medical Care	100% of the Maximum Allowance, no deductible
— Physician office Copayment	$20 per visit
Payment level for Wellness Care	
— **Participating Provider**	100% of the Maximum Allowance
— Office visits	$20 per visit, then 100% of the Maximum Allowance
— **Non-Participating Provider**	60% of the Maximum Allowance
Additional Surgical Opinion	100% of the Claim Charge, no deductible

OTHER COVERED SERVICES

Payment level	80% of the Eligible Charge or Maximum Allowance

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.

DEFINITIONS SECTION

Throughout this Certificate, many words are used which have a specific meaning when applied to your health care coverage. These terms will always begin with a capital letter. When you come across these terms while reading this 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 Blue Shield Plan or Blue Cross 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.

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.

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.

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 Blue Shield Plan or Blue Cross 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 Blue Shield Plan or Blue Cross 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 Blue Shield Plan or Blue Cross 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 Blue Shield Plan or Blue Cross 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 Blue Shield Plan or Blue Cross 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 Blue Shield Plan or Blue Cross 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 Blue Shield Plan or Blue Cross 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 Blue

Shield Plan or Blue Cross 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 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 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 Blue Shield Plan or Blue Cross 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 Blue Shield Plan or Blue Cross 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 Blue Shield Plan or Blue Cross 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 Blue Shield Plan or Blue Cross 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 Blue Shield Plan or Blue Cross 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 Blue Shield Plan or Blue Cross 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.

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

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

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

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

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.

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 Blue Shield Plan or Blue Cross 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 Blue Shield Plan or Blue Cross 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.

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 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.

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 Blue Shield Plan or Blue Cross 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 Blue Shield Plan or Blue Cross Plan to provide services to you at the time services are rendered.

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,

(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.

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.

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.

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).

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.

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 Blue Shield Plan or Blue Cross 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 Blue Shield Plan or Blue Cross 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.

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 Blue Shield Plan or Blue Cross Plan to provide services to you at the time services are rendered to you.

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

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

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

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

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

INVESTIGATIONAL or INVESTIGATIONAL SERVICES AND SUPPLIES.....means procedures, drugs, devices, services and/or supplies which (1) are provided or performed in special settings for research purposes or under a controlled environment and which are being studied for safety, efficiency and effectiveness, and/or (2) are awaiting endorsement by the appropriate National Medical Specialty College or federal government agency for general use by the medical community at the time they are rendered to

you, and (3) specifically with regard to drugs, combination of drugs and/or devices, are not finally approved by the Food and Drug Administration at the time used or administered to you.

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.

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 Blue Shield Plan or Blue Cross 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 Blue Shield Plan or Blue Cross 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 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 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.

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 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.

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 HOSPITAL.....SEE DEFINITION OF HOSPITAL.

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

NON-PARTICIPATING PROVIDER.....SEE DEFINITION OF PROVIDER.

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 Blue Shield Plan or Blue Cross 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 Blue Shield Plan or Blue Cross 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 Blue Shield Plan or Blue Cross 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 Blue Shield Plan or Blue Cross Plan to provide services to you at the time services are rendered.

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

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

PARTICIPATING 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 care benefits designed to provide you with economic incentives for using designated Providers of health care services.

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

PHYSICAL 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.

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 6 months prior to your Enrollment Date. Taking prescription drugs is considered medical treatment even if your condition was diagnosed more than 6 months before your Enrollment

Date. For purposes of this definition, pregnancy or conditions based solely on genetic information are not preexisting conditions.

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.

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 Blue Shield Plan or Blue Cross 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 Blue Shield Plan or Blue Cross 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 Blue Shield Plan or Blue Cross 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 or Professional Provider 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 participants in a Participating Provider Option program or a Plan facility or Professional Provider which has been designated by a Blue Cross and Blue Shield Plan as a Participating Provider.

A "Non-Participating Provider" means a Plan Hospital or Professional Provider which 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 or a facility which has not been designated by Blue Cross and Blue Shield of Illinois as a Participating Provider.

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 Blue Shield Plan or Blue Cross Plan.

A "Participating Prescription Drug Provider" means a Pharmacy that 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 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.

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.

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 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.

ELIGIBILITY SECTION

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

- Meet the definition of an Eligible Person as specified in the Group Policy;
- Have applied for this coverage; and
- Have received a Blue Cross and Blue Shield 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.

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.

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. 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

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 will be covered.

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.

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

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.

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.

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.
- 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.
- 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.

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.

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.

Late Applicants

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. Such changes will be effective on a date that has been mutually agreed to by your Group and Blue Cross and Blue Shield.

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.

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" provisions 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.

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.

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.

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.

MEDICAL SERVICES ADVISORY PROGRAM

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

- Inpatient Hospital services
- Skilled Nursing Facility services
- services received in a Coordinated Home Care Program
- Private Duty Nursing Services

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.

The MSA's toll-free telephone number is on your Blue Cross and Blue Shield identification card. Please read the provisions below very carefully.

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.

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, call the MSA. This call must be made at least one business day prior to the Hospital admission.

  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, notify the MSA no later than two business days or as soon as reasonably possible after the admission has occurred.

- **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, notify the MSA no later than two business days after the admission has occurred in order to have the Inpatient Hospital admission reviewed.

  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.

- **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, call the MSA. This call must be made at least one business day 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.

- **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, call the MSA. This call must be made at least one business day 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.

- **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, call the MSA. This call must be made at least one business day prior to receiving services. When you call the MSA, a case manager may be assigned to you for the duration of your care.

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.

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 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.

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.

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.

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 prior to the Hospital admission.

  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 48 hours 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.

- **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 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.

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. 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.

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 Participating 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.

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.

As a participant in the Participating Provider Option a directory of Participating Providers 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 Providers. While there may be changes in the directory from time to time, selection of 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 will be greater when you use the services of a Participating 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 January 1st of each year. When you first enroll under this coverage, your first benefit period begins on your Coverage Date, and ends on the first December 31st following that date.

YOUR DEDUCTIBLE

Each benefit period you must satisfy a $200 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.

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.

If you have Family Coverage and your family has reached the program deductible amount of $400 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.

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.

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. 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.

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

INPATIENT CARE

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

Inpatient Covered Services

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

Preadmission Testing

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

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

Partial Hospitalization Treatment Program

Benefits 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.

Coordinated Home Care Program

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

BENEFIT PAYMENT FOR INPATIENT HOSPITAL COVERED SERVICES

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 90% of the Eligible Charge, 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.

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 60% of the Eligible Charge, after you have met your program 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.

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.

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.

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 Wellness Care provision of this Certificate. Benefits for mammograms, other than routine, will be provided at the same payment level as Outpatient Diagnostic Service.
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.
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.
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. Benefits will be provided at the benefit payment level described in the Wellness Care provision of this Certificate.
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.

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 Provider

Benefits will be provided at 90% of the Eligible Charge when you receive Outpatient Hospital Covered Services from a Participating Provider, unless otherwise specified in this Certificate. Your program deductible will not apply.

Non-Participating Provider

When you receive Outpatient Hospital Covered Services from a Non-Participating Provider, benefits will be provided at 60% of the Eligible Charge after you have met your program deductible, unless otherwise specified in this Certificate.

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.

Emergency Care

Benefits for Emergency Accident Care will be provided at 100% of the Eligible Charge when you receive Covered Services from either a Participating, Non-Participating or Non-Plan Provider.

Benefits for Emergency Accident Care will not be subject to the program deductible.

Benefits for Emergency Medical Care will be provided at 100% of the Eligible Charge when you receive Covered Services from either a Participating, Non-Participating or Non-Plan Provider.

Benefits for Emergency Medical Care will not be subject to the program deductible.

WHEN SERVICES ARE NOT AVAILABLE FROM A PARTICIPATING PROVIDER (HOSPITAL)

If you must receive Hospital Covered Services which Blue Cross and Blue Shield has reasonably determined are unavailable from a 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. 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;
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 performed by a Physician Assistant under the direct supervision of a Physician, Dentist or Podiatrist.
3. Sterilization Procedures (even if they are elective)

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.

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.

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.

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 will be limited to a maximum of 60 visits per benefit period.

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 60 visits per benefit period.

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. Outpatient Speech Therapy benefits will be limited to a maximum of 60 visits per benefit period. However, benefits will be provided for an additional 20 visits for Speech Therapy for treatment of pervasive developmental disorders.

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.

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.

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.

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 Wellness Care provision of this Certificate. 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.

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.

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.

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.

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.

Acupuncture–Benefits will be provided for acupuncture.

Hearing Examination—Benefits will be provided for an annual hearing examination.

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

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).

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.

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 Participating or Non-Participating Professional Provider.

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 90% of the Maximum Allowance, 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.

When you receive Covered Services in a Participating Provider's office, benefits for office visits are subject to a Copayment of $20 per visit. Benefits for office visits will then be provided at 100% of the Maximum Allowance. Your program deductible will not apply.

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 60% of the Maximum Allowance, unless otherwise specified in this Certificate. Your program deductible will not apply.

Emergency Care

Benefits for Emergency Accident Care other than in the Provider's office will be provided at 100% of the Maximum Allowance when rendered by either a Participating or Non-Participating Provider. 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 $20 per visit. Benefits for office visits will be provided at 100% of the Maximum Allowance.

Benefits for Emergency Medical Care other than in the Provider's office will be provided at 100% of the Maximum Allowance when rendered by either a Participating or Non-Participating Provider. Your program deductible will not apply.

When you receive Covered Services for Emergency Medical Care in a Provider's office, benefits for office visits are subject to a Copayment of $20 per visit. Benefits for office visits will be provided at 100% of the Maximum Allowance.

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.

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 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 Participating Provider, contact your Group Administrator, your Professional Provider or Blue Cross and Blue Shield.

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.
- 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.
- 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
- Naprapathic Service—Benefits will be provided for Naprapathic Services when rendered by a Naprapath.

BENEFIT PAYMENT FOR OTHER COVERED SERVICES

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

When you receive Other Covered Services from a 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.

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 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 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.**

— 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.

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 you, even though you are not ill. Benefits will be limited to the following services:

1. Immunizations;
2. Routine physical examinations;
3. Routine gynecological examinations – one per benefit period;
4. Routine diagnostic tests.

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 90% of the Eligible Charge or 100% of the Maximum Allowance after you have met your program deductible.

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 $20 per visit. Benefits for office visits will then be provided at 100% of the Maximum Allowance after you have met your program deductible.

Non-Participating Provider

When you receive Covered Services for wellness care from a Non-Participating Provider, benefits will be provided at 60% of the Eligible Charge or 60% of the Maximum Allowance after you have met your program deductible.

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 90% of the Eligible Charge.

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

AMBULATORY SURGICAL FACILITY

Benefits for all of the Covered Services previously described in this 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 90% of the Eligible Charge. Benefits for services by a Non-Plan Ambulatory Surgical Facility will be provided at 50% of the Eligible Charge.

Benefits for Outpatient Surgery will be provided as stated above whether or not you have met your program deductible.

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.

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.

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.

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.

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 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.

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.

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.

For Participating Providers

If, during one benefit period, your out-of-pocket expense (the amount remaining unpaid after benefits have been provided) equals $1,000, 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.

This out-of-pocket expense limit may be reached by:

- 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)

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)
- 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
- the Hospital emergency room Copayment
- the Copayment for Physician office visits
- Copayments resulting from noncompliance with the provisions of the Medical Services Advisory Program and/or the Blue Cross and Blue Shield Mental Health Unit

If you have Family Coverage and your out-of-pocket expense as described above equals $2,000 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.

For Non-Participating Providers

If, during one benefit period, your out-of-pocket expense (the amount remaining unpaid after benefits have been provided) equals $3,000, 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.

This out-of-pocket expense limit may be reached by:

- 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)

- 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 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
- the Hospital emergency room Copayment
- Copayments resulting from noncompliance with the provisions of the Medical Services Advisory Program and/or the Blue Cross and Blue Shield Mental Health Unit

If you have Family Coverage and your expense as described above equals $6,000 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.

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.

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.

EXCLUSIONS—WHAT IS NOT COVERED

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

— **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.

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

— 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 primarily related to behavioral, social maladjustment, lack of discipline or other antisocial actions which are not specifically the result of Mental Illness.

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

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

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

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

— Special braces, splints, specialized equipment, appliances, ambulatory apparatus, battery implants, except as specifically mentioned in this Certificate.

— 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.

— 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.

— 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.

— 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.

COORDINATION OF BENEFITS SECTION

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.

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.

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.
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 Ter-

mination" 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 COVERAGE RIGHTS UNDER COBRA

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.

Introduction

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

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

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

What Is COBRA Continuation Coverage?

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

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

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

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

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;

- Your spouse becomes enrolled in Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

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

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

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

When Is COBRA Coverage Available?

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

You Must Give Notice of Some Qualifying Events

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

How Is COBRA Coverage Provided?

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

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

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

Disability Extension Of 18-Month Period Of Continuation Coverage

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

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

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or

both), or gets divorced or legally separated or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

If You Have Questions

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

Keep Your Plan Informed Of Address Changes

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

Plan Contact Information

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

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.

HOW TO FILE A CLAIM

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.

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

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

Should you have any questions about filing Claims, ask your Group Administrator or call your local Blue Cross and Blue Shield office.

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

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 care services to all persons entitled to health care benefits under health policies and contracts to which Blue Cross and Blue Shield is a party, including all persons covered under this 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.

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:

- 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.

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 per-

sons covered under this Certificate. 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.

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. CONFORMITY WITH STATE STATUTES

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.

RIDER TO THE CERTIFICATE FOR DISABLED OR RETIRED PUBLIC EMPLOYEES

The Certificate to which this Rider is attached and becomes a part, is hereby amended as follows:

If you are a public employee and are eligible for continued group accident and health insurance under Sections 367g, 367h and 367j of the Illinois Insurance Code, you may establish and maintain such continued group health insurance coverage under this Certificate, if you meet the following conditions:

1. You and your eligible dependents, must have been insured under this Certificate on the day immediately preceding the effective date of eligibility for continued group health insurance.
2. Once properly established, continued group health insurance under this Certificate may be maintained by you or your surviving spouse, until the loss of eligibility as specified in Sections 367g, 367h and 367j of the Insurance Code. It shall be your responsibility to inform Blue Cross and Blue Shield of the loss of eligibility.
3. The election by you or your surviving spouse, to obtain a conversion policy as described in the conversion provisions of this Certificate shall terminate any right to continue group coverage according to Sections 367g, 367h and 367j of the Insurance Code. No reinstatement of continued group coverage shall be permitted after such conversion has been effected or if the continued group coverage provided by this Rider has been terminated for any reason.
4. If you or your surviving spouse is continuing coverage under this Certificate and becomes eligible for Medicare, the benefits under this Certificate shall be reduced in accordance with the benefit provisions for Medicare Eligibles stated in this Certificate.
5. If a timely and valid election of continued group coverage has been made, you must remit the total monthly premium payment required to establish and maintain such coverage, whether such total monthly premium is contributed by you, deducted from a pension payment or paid directly to your Group by you.

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

Attest:

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

Hugo Tagli Jr.
Secretary

President

RIDER TO THE CERTIFICATE FOR CONTINUED GROUP COVERAGE FOR CERTAIN DISABLED OR RETIRED FIREMEN

The Certificate, to which this Rider is attached and becomes a part, is hereby amended to add the following provisions:

If you are a fireman and are eligible for continued group accident and health insurance under Section 367f of the Illinois Insurance Code, as amended, you may establish and maintain such continued group health insurance coverage only under the following conditions:

1. You and your eligible dependents, if any, must have been insured under the Certificate in effect on the day immediately preceding the day on which such eligibility for continued group coverage begins.
2. Once properly established, continued group coverage may be maintained by you or your surviving spouse, until the loss of eligibility as specified in Section 367f of the Insurance Code. It shall be the responsibility of you or your surviving spouse to inform Blue Cross and Blue Shield of the loss of eligibility.
3. The election by you or your surviving spouse to obtain a conversion policy as described in the Certificate provisions relating to conversion, shall automatically terminate any right to continue group coverage under Section 367f of the Insurance Code. No reinstatement of continued group coverage shall be permitted after such conversion has been in effect or if the continued group coverage provided by this Rider is terminated for any reason.
4. If you or your surviving spouse are continuing coverage under the terms of this Rider and become eligible for Medicare, the benefits under the continued Certificate shall become secondary to the benefits provided under Medicare.
5. If a timely and valid election of continued group coverage has been made, you or your surviving spouse shall remit to Blue Cross and Blue Shield the total monthly premium payment required to establish and maintain the continued group coverage, whether such total monthly premium is contributed by you or your surviving spouse, deducted from a pension payment, paid directly to the Group by you or your surviving spouse, or by any combination of the above.

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

Attest:

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

Hugo Tagli Jr.
Secretary

President

RIDER TO THE CERTIFICATE FOR CONTINUED GROUP COVERAGE FOR CERTAIN PUBLIC SAFETY EMPLOYEES

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

If you are a full-time law enforcement, correctional or correctional probation officer, or firefighter and are eligible for continued group health insurance under the Public Safety Employee Benefits Act (820 ILCS 320), you may maintain such group health insurance under the following conditions:

1. You and your eligible dependents must have been insured under this Certificate on the day immediately preceding the date of eligibility for continued group health insurance.
2. Your Group shall pay the entire premium of the group health insurance coverage for you, your spouse, and each dependent child until the child reaches the limiting age under this Certificate or until the end of the calendar year in which the child reaches the age of 25, if the child continues to be dependent for support, whichever is later.
3. If you subsequently die, your Group shall continue to pay the entire health insurance premium for your surviving spouse until he or she remarries and for your dependent children under the conditions established in 2. above.
4. Health insurance benefits under this Certificate shall be reduced by health insurance benefits payable from any other source.

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 Blue Shield of Illinois)

Hugo Tagli Jr.
Secretary

President

BlueCross BlueShield of Illinois

Experience. Wellness. Everywhere.℠

GB-10 HCSC

Effective Date: December 1, 2010

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

Your Health Care Benefit Program

HMO ILLINOIS
A Blue Cross HMO

a product of

Blue Cross and Blue Shield of Illinois

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Your Health Care Benefit Program

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Experience. Wellness. Everywhere.™

A message from

BLUE CROSS AND BLUE SHIELD

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

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

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

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

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

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

Sincerely,

Patricia A. Hemingway Hall

Patricia A. Hemingway Hall
President and CEO

Deborah Dorman-Rodriguez

Deborah Dorman-Rodriguez
Secretary

GB-16 HCSC

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BENEFIT HIGHLIGHTS

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

PHYSICIAN BENEFITS

— Your Cost for Covered Services (unless specified otherwise below)	None
— Your Cost for Outpatient Office Visits	$3 per Visit
— Your Cost for Outpatient Specialist Physician Visits	$3 per Visit
— Your Cost for Outpatient Office Visits for Periodic Health Examinations or Routine Pediatric Care	$3 per Visit
— Your Cost for Outpatient Office Visits for the Treatment of Mental Illness Other Than Serious Mental Illness, when not authorized by your PCP or WPHCP	50% of Covered Services
— Limit on Number of Outpatient Speech Therapy, Physical Therapy and Occupational Therapy Treatments	60 Treatments each per Calendar Year
— Limit on Number of Outpatient Rehabilitative Therapy Treatments other than Speech Therapy, Physical Therapy and Occupational Therapy	60 Treatments per Calendar Year
Additional Outpatient Visits for Speech Therapy for the Treatment of Pervasive Developmental Disorders	20 Visits per Calendar Year

HOSPITAL BENEFITS

— Your Cost for Inpatient Covered Services	None

— Your Cost for the Inpatient Treatment of Mental Illness Other Than Serious Mental Illness, when not authorized by your PCP or WPHCP	50% of Covered Services
— Your Cost for Outpatient Covered Services	None

SUPPLEMENTAL BENEFITS

— Your Cost for Covered Services	None

EMERGENCY CARE BENEFITS

— Your Cost for an In-Area Emergency	None
— Your Cost for an Out-of-Area Emergency	None
— Your Cost for Emergency Ambulance Transportation	None

CHEMICAL DEPENDENCY TREATMENT BENEFITS

— Your Cost for Inpatient Chemical Dependency Treatment	None
— Your Cost for Outpatient Office Visits for Chemical Dependency Treatment	$3 per Visit
— Your Cost for Outpatient Specialist Physician Visits for Chemical Dependency Treatment	$3 per Visit

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

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ELIGIBILITY

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

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

REPLACEMENT OF DISCONTINUED GROUP COVERAGE

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

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

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

INDIVIDUAL COVERAGE

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

FAMILY COVERAGE

Under Family Coverage, your health care expenses and those of your enrolled spouse and your (and/or your spouse's) unmarried children who are under the limiting age specified in the BENEFIT HIGHLIGHTS section will be covered. A Domestic Partner and his or her children who have not attained the limiting age specified in the BENEFIT HIGHLIGHTS section are also eligible dependents. All of the provisions of this Certificate that pertain to a spouse also apply to a Domestic Partner unless specifically noted otherwise.

In addition, enrolled unmarried children will be covered up to the age of 30 if they:

- Live within the Plan's service area; 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.

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

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

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

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

MEDICARE ELIGIBLE COVERED PERSONS

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

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

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

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

Your MSP Responsibilities

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

YOUR IDENTIFICATION CARD

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

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

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

— Marriage.

— Birth, adoption or placement for adoption of a child.

— Obtaining legal guardianship of a child.

— The establishment of a Domestic Partnership.

— Loss of eligibility for other health coverage for you or your dependent if:

a. The other coverage was in effect when you were first eligible to enroll for this coverage;

b. The other coverage is not terminating for cause (such as failure to pay premiums or mailing a fraudulent claim); and

c. Where required, you stated in writing that coverage under another group health plan or other health insurance coverage was the reason for declining enrollment in this coverage.

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

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

b. In the case of HMO, 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 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 dependent(s) will be effective from the date of the event if you apply for this change within 31 days of any of the following events:

— Marriage.

— Birth, adoption or placement for adoption of a child.

— Obtaining legal guardianship of a child.

— The establishment of a Domestic Partnership.

— Loss of eligibility for other coverage for you or your dependent, except for loss of coverage due to reaching a lifetime limit on all benefits.

— Termination of employer contributions towards your or your dependent's other coverage.

— Exhaustion of COBRA continuation or state continuation coverage.

If coverage is lost in another group health plan because a lifetime limit on all benefits is reached under that coverage and you apply for Family Coverage or to add dependents within 31 days after a claim is denied due to reaching the lifetime

limit, your Family Coverage or the coverage for your additional dependents will be effective from the date your claim was denied.

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 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.

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

LATE APPLICANTS

If you do not apply for Family Coverage or to add dependents within the allotted time, you will have to wait until your Group's annual open enrollment period to do so. Your Family Coverage or the coverage for your additional dependents will then be effective on the first day of the month following the open enrollment period. Benefits will not be provided for any treatment of an illness or injury to a newborn child unless you have Family Coverage. (Remember, you must add the newborn child within 31 days of the date of birth.)

CHANGING FROM FAMILY TO INDIVIDUAL COVERAGE

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

TERMINATION OF COVERAGE

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

— You no longer meet the previously stated description of an Eligible Person; or

— The entire coverage of your Group terminates.

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

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

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

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

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

Extension of Benefits in Case of Discontinuance of Coverage

If you are Totally Disabled at the time your entire Group terminates, benefits will be provided for (and limited to) the Covered Services described in this Certificate which are related to the disability. Benefits will be provided when no coverage is available under the succeeding carrier's policy whether due to the absence of coverage in the policy or lack of required Creditable Coverage for a preexisting condition. Benefits will be provided for a period of no more than 12 months from the date of termination. These benefits are subject to all of the terms and conditions of this Certificate including, but not limited to, the requirements regarding Primary Care Physician referral. It is your responsibility to notify the Plan, and to provide, when requested by the Plan, written documentation of your disability.

CONTINUATION COVERAGE RIGHTS UNDER COBRA

This CONTINUATION COVERAGE RIGHTS UNDER COBRA provision does not apply to Domestic Partners and their children.

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.

Introduction

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

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

of your family who are covered under the Plan when they would otherwise lose their group health coverage.

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

What Is COBRA Continuation Coverage?

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

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

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

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

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

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

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

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

When Is COBRA Coverage Available?

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

You Must Give Notice of Some Qualifying Events

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

How Is COBRA Coverage Provided?

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

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

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

when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability Extension of 18-Month Period of Continuation Coverage

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

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

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

If You Have Questions

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

Keep Your Plan Informed of Address Changes

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

Plan Contact Information

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

COVERAGE AFTER TERMINATION (Illinois State Laws)

This COVERAGE AFTER TERMINATION provision does not apply to Domestic Partners and their children.

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

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

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

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

1. Continuation of coverage will be available to you only if you have been continuously 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 or (b) you have coverage under any other health care program which provides group hospital, surgical or medical coverage and under which you were not covered immediately prior to such termination or reduction in hours below the minimum required for eligibility, or (c) you decide to become a member of the Plan on a "direct pay" basis.
3. If you decide to become a member of the Plan on a "direct pay" basis, you may not, at a later date, elect the continuation of coverage option under this Certificate. Upon termination of the continuation of coverage period as explained in paragraph 6 below, you may exercise the Conversion Privilege explained in the ELIGIBILITY section of this Certificate.

4. Upon termination of employment or membership or reduction in hours below the minimum required for eligibility, your Group will provide you with written notice of this option to continue your coverage. If you decide to continue your coverage, you must notify your Group, in writing, no later than 10 days after your coverage has terminated or reduction in hours below the minimum required for eligibility or 10 days after the date you received notice from your Group of this option to continue coverage. However, in no event will you be entitled to your continuation of coverage option more than 60 days after your termination or reduction in hours below the minimum required for eligibility.
5. If you decide to continue your coverage under this Certificate, you must pay your Group on a monthly basis, in advance, the total charge required by the Plan for your continued coverage, including any portion of the charge previously paid by your Group. Payment of this charge must be made to the Plan (by your Group) on a monthly basis, in advance, for the entire period of your continuation of coverage under this Certificate.
6. Continuation of coverage under this Certificate will end on the date you become eligible for Medicare, become a member of the Plan on a "direct pay" basis or become covered under another health care program (which you did not have on the date of your termination or reduction in hours below the minimum required for eligibility) which provides group hospital, surgical or medical coverage. However, your continuation of coverage under this Certificate will also end on the first to occur of the following:
   a. Nine months after the date the Eligible Person's coverage under this Certificate would have otherwise ended because of termination of employment or membership or reduction in hours below the minimum required for eligibility.
   b. If you fail to make timely payment of required charges, coverage will terminate at the end of the period for which your charges were paid.
   c. The date on which the Group Policy is terminated. However, if this Certificate is replaced by similar coverage under another group policy, the Eligible Person will have the right to become covered under the new coverage for the amount of time remaining in the continuation of coverage period.

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

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

1. Continuation will be available to you as the former spouse of an Eligible Person or spouse of a retired Eligible Person only if you provide the employ-

er of the Eligible Person with written notice of the dissolution of marriage, the death or retirement of the Eligible Person within 30 days of such event.

2. Within 15 days of receipt of such notice, the employer of the Eligible Person will give written notice to the Plan of the dissolution of your marriage to the Eligible Person, the death of the Eligible Person or the retirement of the Eligible Person as well as notice of your address. Such notice will include the Group number and the Eligible Person's identification number under this Certificate. Within 30 days of receipt of notice from the employer of the Eligible Person, the Plan will advise you at your residence, by certified mail, return receipt requested, that your coverage and your covered dependents under this Certificate may be continued. The Plan's notice to you will include the following:

   a. a form for election to continue coverage under this Certificate.

   b. notice of the amount of monthly charges to be paid by you for such continuation of coverage and the method and place of payment.

   c. instructions for returning the election form within 30 days after the date it is received from the Plan.

3. In the event you fail to provide written notice to the Plan within the 30 days specified above, benefits will terminate for you on the date coverage would normally terminate for a former spouse or spouse of a retired Eligible Person under this Certificate as a result of the dissolution of marriage, the death or the retirement of the Eligible Person. Your right to continuation of coverage will then be forfeited.

4. If the Plan fails to notify you as specified above, all charges shall be waived from the date such notice was required until the date such notice is sent and benefits shall continue under the terms of this Certificate from the date such notice is sent, except where the benefits in existence at the time of the Plan's notice was to be sent are terminated as to all Eligible Persons under this Certificate.

5. If you have not reached age 55 at the time your continued coverage begins, the monthly charge will be computed as follows:

   a. an amount, if any, that would be charged to you if you were an Eligible Person, with Individual or Family Coverage, as the case may be, plus

   b. an amount, if any, that the employer would contribute toward the charge if you were the Eligible Person under this Certificate.

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

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

7. Termination of Continuation of Coverage:

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

   a. if you fail to make any payment of charges when due (including any grace period specified in the Group Policy).

   b. on the date coverage would otherwise terminate under this Certificate if you were still married to the Eligible Person; however, your coverage shall not be modified or terminated during the first 120 consecutive days following the Eligible Person's death or entry of judgment dissolving the marriage existing between you and the Eligible Person, except in the event this entire Certificate is modified or terminated.

   c. the date on which you remarry.

   d. the date on which you become an insured employee under any other group health plan.

   e. the expiration of 2 years from the date your continued coverage under this Certificate began.

8. If you have reached age 55 at the time your continued coverage begins, your continuation of coverage shall end on the first to occur of the following:

   a. if you fail to make any payment of charges when due (including any grace period specified in the Group Policy).

   b. on the date coverage would otherwise terminate, except due to the retirement of the Eligible Person under this Certificate if you were still married to the Eligible Person; however, your coverage shall not be modified or terminated during the first 120 consecutive days following the Eligible Person's death, retirement or entry of judgment dissolving the marriage existing between you and the Eligible Person, except in the event this entire Certificate is modified or terminated.

   c. the date on which you remarry.

   d. the date on which you become an insured employee under any other group health plan.

   e. the date upon which you reach the qualifying age or otherwise establish eligibility under Medicare.

9. If you exercise the right to continuation of coverage under this Certificate, you shall not be required to pay charges greater than those applicable to any other Eligible Person covered under this Certificate, except as specifically stated in these provisions.

10. Upon termination of your continuation of coverage, you may exercise the privilege to become a member of the Plan on a "direct pay" basis as specified in the Conversion Privilege of the ELIGIBILITY section of this Certificate.

11. If this entire Certificate is cancelled and another insurance company contracts to provide group health insurance at the time your continuation of coverage is in effect, the new insurer must offer continuation of coverage to you under the same terms and conditions described in this Certificate.

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

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

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

benefits shall continue under the terms of this Certificate from the date such notice is sent, except where the benefits in existence at the time of the Plan's notice was to be sent are terminated as to all Eligible Persons under this Certificate.

6. The monthly charge will be computed as follows:
   a. an amount, if any, that would be charged to you if you were an Eligible Person, plus
   b. an amount, if any, that the employer would contribute toward the charge if you were the Eligible Person under this Certificate.

   Failure to pay the initial monthly charge within 30 days after receipt of notice from the Plan as required in this Article will terminate your continuation benefits and the right to continuation of coverage.
7. Continuation of Coverage shall end on the first to occur of the following:
   a. if you fail to make any payment of charges when due (including any grace period specified in the Group Policy).
   b. on the date coverage would otherwise terminate under this Certificate if you were still an eligible dependent child of the Eligible Person.
   c. the date on which you become an insured employee, after the date of election, under any other group health plan.
   d. the expiration of 2 years from the date your continued coverage under this Certificate began.
8. If you exercise the right to continuation of coverage under this Certificate, you shall not be required to pay charges greater than those applicable to any other Eligible Person covered under this Certificate, except as specifically stated in these provisions.
9. Upon termination of your continuation of coverage, you may exercise the privilege to become a member of the Plan on a "direct pay" basis as specified in the Conversion Privilege of the ELIGIBILITY section of this Certificate.
10. If this entire Certificate is cancelled and another insurance company contracts to provide group health insurance at the time your continuation of coverage is in effect, the new insurer must offer continuation of coverage to you under the same terms and conditions described in this Certificate.

Other options that may be available for continuation of coverage are explained in the Continuation of Coverage sections of this Certificate.

CONVERSION

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

If you choose to convert your Group coverage to direct-payment coverage, you may not, at a later date, select the continuation of group coverage option. Howev-

er, the conversion privilege will be available when the continuation of coverage period ends.

CONVERSION PRIVILEGE

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

In order to convert your coverage you should:

— Contact the Plan to get an application.

— Send the application to the Plan within 31 days of the date that your coverage is terminated.

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

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

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

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

YOUR PRIMARY CARE PHYSICIAN

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

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

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

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

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

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

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

receiving either emergency care, Chemical Dependency Treatment, treatment for Mental Illness other than Serious Mental Illness or routine vision examinations. These benefits are explained in detail in the EMERGENCY CARE BENEFITS, CHEMICAL DEPENDENCY TREATMENT BENEFITS, HOSPITAL BENEFITS sections and, for routine vision examinations or Mental Illness other than Serious Mental Illness, in the PHYSICIAN BENEFITS section of this Certificate. It is important that you understand the provisions of those sections.

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

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

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

Changing Your Participating IPA/Participating Medical Group

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

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

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

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

You may select a Participating IPA/Participating Medical Group for your newborn child. Your newborn will remain with the mother's Participating IPA/Participating Medical Group/Woman's Principal Health Care Provider, if one has been selected, from the date of birth to the end of the month in which he/she is discharged from the Hospital. Your newborn may be added to the selected Participating IPA/Participating Medical Group on the first day of the month following discharge from the Hospital.

Transition of Care Benefits

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

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

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

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

PHYSICIAN BENEFITS

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

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

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

COVERED SERVICES

Your coverage includes benefits for the following Covered Services:

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

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

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

The following services are also part of your surgical benefits:

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

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

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

Medical Care

Benefits will be provided for Medical Care rendered to you:

— when you are an Inpatient in a Hospital or Skilled Nursing Facility;

— when you are a patient in a Partial Hospitalization Treatment Program or Home Health Care Program; or

— on an Outpatient basis in your Physician's office or your home.

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

Benefits for the treatment of Mental Illness is also a benefit under your Medical Care coverage. In addition to a Physician, Mental Illness rendered under the supervision of a Physician by a clinical social worker or other mental health professional is covered.

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

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

Covered Services include, but are not limited to:

— mammograms;

— clinical breast examinations;

— routine cervical smears or Pap smears;

— routine prostate-specific antigen tests and digital rectal examinations;

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

— ovarian cancer screening — using CA-125 serum tumor marker testing, transvaginal ultrasound and pelvic examination.

Benefits will also be provided for pre-marital examinations that are required by state or federal law. Benefits are not available for examinations done for insurance or employment screening purposes.

Routine Pediatric Care — that is, the routine health care of infants and children including examinations, tests, immunizations and diet regulation. Children are el-

igible for benefits for these services as often as is felt necessary by their Primary Care Physician.

Benefits will also be provided for pre-school or school examinations that are required by state or federal law. Benefits are not available for recreational/camp physicals or sports physicals.

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

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

In addition, benefits will be provided for a human papillomavirus (HPV) vaccine and a shingles vaccine approved by the federal Food and Drug Administration.

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.

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

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

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

Outpatient Rehabilitative Therapy — including, but not limited to, Speech Therapy, Physical Therapy and Occupational Therapy. Treatment, as determined by your Primary Care Physician or Woman's Principal Health Care Provider, must be either (a) limited to therapy which is expected to result in significant improvement within two months in the condition for which it is rendered, or (b) prescribed as preventive or Maintenance Physical Therapy for members affected by multiple sclerosis, subject to the benefit maximum. Benefits for Outpatient Speech Therapy, Physical Therapy and Occupational Therapy each will be subject to a maximum of 60 treatments per calendar year; benefits for all other Outpatient rehabilitative therapies will be subject to a combined maximum of 60 treatments per calendar year.

Outpatient Speech Therapy for Pervasive Developmental Disorders — Benefits will be provided for 20 Outpatient Speech Therapy visits for pervasive developmental disorders per calendar year as determined by your Primary Care Physician or Woman's Principal Health Care Provider. These visits are in addition to the maximum as previously described for Outpatient rehabilitative therapy.

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

Chiropractic and Osteopathic Manipulation — Benefits will be provided for manipulation or adjustment of osseous or articular structures, commonly referred

to as chiropractic and osteopathic manipulation, when performed by a person licensed to perform such procedures.

Hearing Screening — when done to determine the need for hearing correction. Benefits will not be provided for hearing aids, unless otherwise specified in this Certificate.

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

Routine Vision Examinations — benefits will be provided for a routine vision examination, limited to one visit per a 12 month period, without a referral from your Primary Care Physician or Woman's Principal Health Care Provider for vision examinations done to determine the need for vision correction including determination of the nature and degree of refractive errors of the eyes.

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

Benefits will not be provided for eyeglasses or contact lenses, unless otherwise specified in this Certificate.

Dental Accident Care — that is, dental services rendered by a Dentist or Physician which are required as the result of an accidental injury. However, these services are covered only if the injury is to sound natural teeth. A sound natural tooth is any tooth that has an intact root or is part of a permanent bridge.

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

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

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

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

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

Infertility Treatment

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

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

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

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

— you have been unable to attain or sustain a successful pregnancy through reasonable, less costly medically appropriate infertility treatments; however, this requirement will be waived if you or your partner has a medical condition that renders such treatment useless); and

— you have not undergone four (4) completed oocyte retrievals, except that if a live birth followed a completed oocyte retrieval, two (2) more completed oocyte retrievals shall be covered.

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

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

Benefits will not be provided for the following:

1. Reversal of voluntary sterilization. However, in the event a voluntary sterilization is successfully reversed, benefits will be provided if your diagnosis meets the definition of "infertility" as stated above.

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

In addition to the above provisions, in vitro fertilization, gamete intrafallopian tube transfer, zygote intrafallopian tube transfer, low tubal ovum transfer and intracytoplasmic sperm injection procedures must be performed at medical facilities that conform to the American College of Obstetrics and Gynecology guidelines for in vitro fertilization clinics or to the American Society for Reproductive Medicine minimal standards for programs of in vitro fertilization.

Mastectomy Related Services

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

Maternity Services

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

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

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

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

Your coverage also includes benefits for elective abortions, if legal where performed, limited to a lifetime maximum of two abortions.

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

URGENT CARE

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

Payment for Urgent Care Treatment

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

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

FOLLOW-UP CARE

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

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

Payment for Follow-Up Care Treatment

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

COST TO YOU FOR PHYSICIAN SERVICES

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

Benefits for all Outpatient office visits, except for Surgery or maternity services after the first pre-natal visit, are subject to a Copayment of $3 per visit, unless otherwise specified in this Certificate, and then will be paid in full when such services are received from a:

- Physician
- Physician Assistant
- Certified Nurse Midwife
- Certified Nurse Practitioner
- Certified Registered Nurse Anesthetist
- Certified Clinical Nurse Specialist
- Marriage and Family Therapist

Benefits for Outpatient office visits for periodic health examinations, routine pediatric care and routine vision examinations are subject to a Copayment of $3 per visit and then will be paid in full.

Benefits for Outpatient visits to a Specialist Physician's office are subject to a Copayment of $3 per visit and then will be paid in full.

Benefits for Outpatient office visits for the treatment of Mental Illness other than Serious Mental Illness will be provided at 50% of Covered Services when such treatment is not authorized by your Primary Care Physician or Woman's Principal Health Care Provider.

HOSPITAL BENEFITS

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

Remember, to receive benefits for Covered Services, (except for Mental Illness other than Serious Mental Illness), they must be ordered or approved by your Primary Care Physician or Woman's Principal Health Care Provider.

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

COVERED SERVICES

Inpatient Care

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

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

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

Number of Inpatient Days

There are no limits on the number of days available to you for Inpatient care in a Hospital or other eligible facility.

Outpatient Care

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

1. **Surgery** — when performed in a Hospital or Ambulatory Surgical Facility.
2. **Diagnostic Services** — that is, tests performed to diagnose your condition because of your symptoms or to determine the progress of your illness or injury.
3. **Radiation Therapy** — that is, the use of ionizing radiation in the treatment of a medical illness or condition.
4. **Chemotherapy** — that is, the treatment of malignancies with drugs.
5. **Electroconvulsive Therapy**

6. **Renal Dialysis Treatments and Continuous Ambulatory Peritoneal Dialysis Treatment** — when received in a Hospital or a Dialysis Facility. Benefits for treatment in your home are available if you are homebound (that is, unable to leave home without assistance and requiring supportive devices or special transportation) and are rendered under the supervision of a Hospital or Dialysis Facility health care professional.

Special Programs

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

1. **Coordinated Home Care Program**
2. **Pre-Admission Testing** — This is a program in which preoperative tests are given to you as an Outpatient in a Hospital to prepare you for Surgery that you are scheduled to have as an Inpatient.
3. **Partial Hospitalization Treatment Program** — This is a therapeutic treatment program in a Hospital for patients with Mental Illness.

Surgical Implants

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

Maternity Services

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

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

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

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

Your coverage also includes benefits for elective abortions, if legal where performed, limited to a lifetime maximum of two abortions.

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

URGENT CARE

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

Payment for Urgent Care Treatment

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

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

FOLLOW-UP CARE

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

Payment for Follow-Up Care Treatment

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

BENEFIT PAYMENT FOR HOSPITAL SERVICES

100% of the Provider's Charge will be paid when you receive the Covered Services of this benefit section, except as specifically mentioned below.

50% of the Provider's Charge will be paid when you receive Covered Services for the Inpatient treatment of Mental Illness other than Serious Mental Illness, when not authorized by your Primary Care Physician or Woman's Principal Health Care Provider.

SUPPLEMENTAL BENEFITS

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

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

COVERED SERVICES

Your coverage includes benefits for the following Covered Services:

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

  Adjustments, repairs and replacements of these devices, appliances and implants are also covered when required because of wear or a change in your condition. Benefits will not be provided for dental appliances or hearing aids or for replacement of cataract lenses unless a prescription change is required.
- **Durable Medical Equipment** — that is, durable equipment which primarily serves a medical purpose, is appropriate for home use and generally is not useful in the absence of injury or disease. Benefits will be provided for the rental of a piece of equipment (not to exceed the total cost of equipment) or purchase of the equipment. Durable medical equipment must be rented or purchased from a Plan contracting durable medical equipment provider. Contact your Participating IPA/Participating Medical Group prior to purchasing or renting such equipment.

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

PAYMENT FOR COVERED SERVICES

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

EMERGENCY CARE BENEFITS

This section of your Certificate explains your emergency care benefits.

IN-AREA TREATMENT OF AN EMERGENCY

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

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

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

Payment for In-Area Emergency Treatment

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

Should you be admitted to the Hospital as an Inpatient, benefits will be paid as explained in the Hospital Benefits and Physician Benefits Sections of this Certificate.

OUT-OF-AREA TREATMENT OF AN EMERGENCY

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

Payment for Out-of-Area Emergency Treatment

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

Should you be admitted to the Hospital as an Inpatient, benefits will be paid as explained in the Hospital Benefits and Physician Benefits Sections of this Certificate.

EMERGENCY AMBULANCE BENEFITS

Benefits for emergency ambulance transportation are available when:

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

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

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

CHEMICAL DEPENDENCY TREATMENT BENEFITS

Your coverage includes benefits for the treatment of Chemical Dependency.

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

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

Inpatient Benefits

There are no limits on the number of days available to you for Inpatient care in a Hospital or other eligible facility.

Benefits for Inpatient Chemical Dependency Treatment will be paid at 100% of the Provider's Charge.

Outpatient Benefits

Benefits for Outpatient office visits for Chemical Dependency Treatment are subject to a $3 Copayment per visit and then will be paid at 100% of the Provider's Charge.

However, benefits for Outpatient Chemical Dependency Treatment visits to a Specialist Physician's office are subject to a Copayment of $3 per visit and then will be paid in full.

Detoxification

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

AWAY FROM HOME CARE® BENEFITS

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

GUEST MEMBERSHIP

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

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

This would apply for members who are:

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

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

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

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

Benefits for Guest Membership

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

HUMAN ORGAN TRANSPLANT BENEFITS

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

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

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

— If both the donor and recipient have coverage with the Plan, each will have his/her benefits paid by his or her own program.

— If you are the recipient and your donor does not have coverage from any other source, the benefits of this Certificate will be provided for both you and your donor. The benefits provided for your donor will be charged against your coverage under this Certificate.

— If you are the donor and coverage is not available to you from any other source, the benefits of this Certificate will be provided for you. However, benefits will not be provided for the recipient.

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

— You and your companion are each entitled to benefits for lodging and meals up to a combined maximum of $200 per day.

— Benefits for transportation, lodging and meals are limited to a maximum of $10,000 per transplant.

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

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

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

HOSPICE CARE BENEFITS

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

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

The following services are covered under the Hospice Care Program:

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

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

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

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

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

PRE-ADMISSION CERTIFICATION AND CONCURRENT REVIEW

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

PRE-ADMISSION CERTIFICATION

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

CONCURRENT REVIEW

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

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

EXCLUSIONS — WHAT IS NOT COVERED

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

— Services or supplies that are not specifically stated in this Certificate.

— Services or supplies that were not ordered by your Primary Care Physician or Woman's Principal Health Care Provider except as explained in the EMERGENCY CARE BENEFITS section, CHEMICAL DEPENDENCY TREATMENT BENEFITS section, HOSPITAL BENEFITS section and, for Mental Illness (other than Serious Mental Illness) or routine vision examinations, in the PHYSICIAN BENEFITS section of this Certificate.

— Services or supplies that were received prior to the date your coverage began or after the date that your coverage was terminated.

— Services or supplies for which benefits have been paid under any Workers' Compensation Law or other similar laws whether or not you make a claim for such compensation or receive such benefits. However, this exclusion shall not apply if you are a corporate officer of any business or enterprise, defined as a "small business" under paragraph (b), Section 3 or the Illinois Small Business Purchasing Act, as amended, and are employed by the corporation and elect to withdraw yourself from the operation of the Illinois Workers' Compensation Act according to the provisions of the Act.

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

— Services or supplies rendered to you as the result of an injury caused by another person to the extent that you have collected damages for such injury and that the Plan has provided benefits for the services or supplies rendered in connection with such injury.

— Services or supplies that do not meet accepted standards of medical or dental practice including, but not limited to, services which are Investigational in nature.

— Custodial Care Service.

— Long Term Care Services.

— Respite Care Services, except as specifically mentioned under Hospice Care Benefits.

— Services or supplies rendered because of behavioral, social maladjustment, lack of discipline or other antisocial actions which are not specifically the result of Mental Illness.

— Special education therapy such as music therapy or recreational therapy.

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

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

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

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

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

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

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

— Nutritional items such as infant formula, weight-loss supplements, over-the-counter food substitutes, non-prescription vitamins and herbal supplements.

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

— Marriage counseling.

— Hypnotism.

— Inpatient and Outpatient Private Duty Nursing Service.

— Routine foot care, except for persons diagnosed with diabetes.

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

— Maintenance Care.

— Self-management training, education and medical nutrition therapy, except as specifically mentioned in this Certificate.

— Services or supplies which are rendered for the care, treatment, filling, removal, replacement or artificial restoration of the teeth or structures directly supporting the teeth except as specifically mentioned in this Certificate.

— Treatment of temporomandibular joint syndrome with intraoral prosthetic devices or any other method which alters vertical dimension or treatment of temporomandibular joint dysfunction not caused by documented organic joint disease or physical trauma.

— Services or supplies rendered for human organ or tissue transplants except as specifically provided for in this Certificate.

— Wigs (also referred to as cranial prostheses).

— Services or supplies rendered for infertility treatment except as specifically provided for in this Certificate.

— Outpatient prescription drugs or medicines.

COORDINATION OF BENEFITS

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

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

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

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

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

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

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

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

(i) Group insurance or group-type coverage, whether insured or uninsured. This includes prepayment, group practice or individual practice coverage.

(ii) Coverage under a governmental plan, or coverage required or provided by law. This does not include a state plan under Medicaid (Title XIX of the Social Security Act).

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

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

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

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

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

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

ORDER OF BENEFIT DETERMINATION

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

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

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

1. Non-Dependent or Dependent

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

   a. Secondary to the Benefit Program covering the person as a dependent; and
   b. Primary to the Benefit Program covering the person as other than a dependent, for example a retired employee.

2. Dependent Child if Parents not Separated or Divorced

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

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

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

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

3. Dependent Child if Parents Separated or Divorced

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

a. First, the program of the parent with custody of the child;

b. Then, the program of the spouse of the parent with the custody of the child; and

c. Finally, the program of the parent not having custody of the child.

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

4. Dependent Child if Parents Share Joint Custody

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

5. Active or Inactive Employee

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

6. Continuation Coverage

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

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

b. Second, the benefits under the continuation coverage.

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

7. Length of Coverage

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

WHEN THIS BENEFIT PROGRAM IS A SECONDARY PROGRAM

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

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

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

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

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

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

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

FACILITY OF PAYMENT

A payment made under another Benefit Program may include an amount which should have been paid under this Benefit Program. If it does, the Plan may pay that amount to the organization which made that payment. That amount will then be treated as though it were a benefit paid under this Benefit Program. The Plan will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

RIGHT OF RECOVERY

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

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

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

REDUCTION IN BENEFITS

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

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

HOW TO FILE A CLAIM

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

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

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

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

Mail all of that information to:

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

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

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

CLAIM PROCEDURES

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

Claims and Assignment of Benefits" provision in the OTHER THINGS YOU SHOULD KNOW section of this Certificate.)

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

CLAIM REVIEW PROCEDURES

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

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

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

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

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

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

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

INQUIRIES AND COMPLAINTS

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

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

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

- Claims

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

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

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

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

APPEALS

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

An appeal is an oral or written request for a review of an adverse decision or action by the Plan, its employees, or the Participating Medical Group/IPA. An appeal may be filed by you, a person designated to act on your behalf, your Primary Care Physician or Woman's Principal Health Care Provider or any health care provider.

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

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

URGENT/EXPEDITED CLINICAL APPEALS

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

CLINICAL APPEALS

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

NOTIFICATION

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

The written notification will include:

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

EXPEDITED EXTERNAL INDEPENDENT REVIEW

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

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

EXTERNAL INDEPENDENT REVIEW

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

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

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

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

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

NON-CLINICAL APPEALS

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

NOTIFICATION

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

The written notification will include:

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

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

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

or

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

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

OTHER THINGS YOU SHOULD KNOW

REIMBURSEMENT PROVISION

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

a. the Plan has the right to reimbursement for all benefits the Plan provided from any and all damages collected from the third party for those same expenses, whether by action at law, settlement, or compromise, by you or your legal representative as a result of that sickness or injury:

   (i) in the case of health care facilities and certain contracted Providers, the calculation of any lien shall be based on the amount the Plan charges the group's experience for Covered Services rendered to you; and

   (ii) in the case of Providers other than health care facilities, the calculation of any lien shall be based on the Plan's benefit payment for Covered Services rendered to you.

b. the Plan is assigned the right to recover from the third party, or his or her insurer, to the extent of the benefits the Plan provided for that sickness or injury. The Plan shall have the right to first reimbursement out of all funds you, your covered dependents or your legal representative, are or were able to obtain for the same expenses the Plan has provided as a result of that sickness or injury.

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

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

PLAN'S SEPARATE FINANCIAL ARRANGEMENTS WITH PROVIDERS

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

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

— receive substantial payments from Providers or suppliers with respect to goods, supplies and services furnished to all such persons for which the Plan was obligated to pay the Provider or supplier, or

— pay Providers or suppliers substantially less than their Claim Charges for goods or services, by discount or otherwise, or

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

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

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

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

BlueCard

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

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

— The billed charges for your Covered Services, or

— The negotiated price that the Host Blue passes on to the Plan.

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

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

PLAN'S SEPARATE FINANCIAL ARRANGEMENTS REGARDING PRESCRIPTION DRUGS

Plan's Separate Financial Arrangements with Prescription Drug Providers

The Plan hereby informs you that it has contracts, either directly or indirectly, with prescription drug providers ("Participating Prescription Drug Providers") to provide prescription drug services to all persons entitled to prescription drug benefits under health policies and contracts to which the Plan is a party, including all persons covered under this Certificate. Under its contracts with Participating Prescription Drug Providers, the Plan may receive from these providers discounts for prescription drugs dispensed to you.

Plan's Separate Financial Arrangements with Pharmacy Benefit Managers

The Plan owns a significant portion of the equity of Prime Therapeutics LLC and informs you that the Plan has entered into one or more agreements with Prime Therapeutics LLC or other entities (collectively referred to as "Pharmacy Benefit Managers") to provide, on the Plan'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 the Plan. Neither the Group nor you are entitled to receive any portion of such rebates as they are figured into the pricing of the product.

PAYMENT OF CLAIMS AND ASSIGNMENT OF BENEFITS

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

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

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

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

COVERED SERVICES EXPENSE LIMITATION

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

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

Copayments and deductibles required under this Certificate are not to exceed 50% of the usual and customary fee for any single service.

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

YOUR PROVIDER RELATIONSHIPS

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

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

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

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

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

ENTIRE POLICY

The Group Policy, including the Certificate, any Addenda and/or Riders, the Benefit Program Application of the Group for the Policy and the individual applications, if any, of the Enrollees constitutes the entire contract of coverage between the Group and the Plan.

AGENCY RELATIONSHIPS

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

NOTICES

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

LIMITATIONS OF ACTIONS

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

INFORMATION AND RECORDS

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

DEFINITIONS

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

Ambulatory Surgical 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.

Certificate .....means this booklet and your application for coverage under the Plan 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.

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.

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.

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

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

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

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

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

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

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

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

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 employees and their family members whose coverage would otherwise terminate under the terms of this Certificate.

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.)

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

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

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:

a) A group health plan.

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

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

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

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

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

g) A State health benefits risk pool.

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

i) A public health plan established or maintained by a State or any political subdivision of a State, the U.S. government or a foreign country.

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

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

Custodial Care 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 or professional training and clinical assessment ability of medical and/or nursing personnel in order to be safely and effectively performed. These services can be safely provided by trained or capable non-professional personnel, are to assist with routine medical needs (e.g. simple care and dressings, administration of routine medications etc.) and are to assist with activities of daily living, (e.g. bathing, eating, dressing, etc.). Custodial Care Service also means providing care on a continuous Inpatient or Outpatient basis without any clinical improvement by you.

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

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

Dialysis 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.

Domestic Partner .....means a person with whom you have entered into a Domestic Partnership.

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

a) You and your Domestic Partner have lived together for at least six months;

b) Neither you nor your Domestic Partner is married to anyone else or has another domestic partner;

c) Both you and your Domestic Partner are at least 18 years of age and mentally competent to consent to contract;

d) You and your Domestic Partner reside together and intend to do so indefinitely;

e) You and your Domestic Partner have an exclusive mutual commitment similar to marriage; and

f) You and your Domestic Partner are jointly responsible for each other's common welfare and share financial obligations.

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

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

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

b) serious impairment to bodily functions; or

c) serious dysfunction of any bodily organ or part.

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

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

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).

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

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

Hospice Care Program Provider .....means an organization duly licensed to provide Hospice Care Program service.

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

Individual Coverage .....means that your application for coverage was only for yourself.

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

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

Long Term Care 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 a 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/or measurable improvement of a condition will occur.

Marriage and Family Therapist .....means a duly licensed marriage and family therapist.

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

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

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 implementing regulations set forth in 42 C.F.R. Part 411, as amended, which regulate the manner in which certain employers may offer group health care coverage to Medicare-eligible employees, their spouses and, in some cases, dependent children.

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

"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.

Non-Clinical Appeal .....means an appeal of non-clinical issues, such as appeals pertaining to benefits and administrative procedures.

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

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

Optometrist .....means a duly licensed optometrist.

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

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

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

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

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

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

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

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

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

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

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

Prescription Drug Provider .....means any Pharmacy which regularly dispenses drugs.

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

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

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

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

Psychologist .....means:

a) a Clinical Psychologist who is registered with the Illinois Department of Professional Regulation pursuant to the Illinois "Psychologist Registration Act" (111 Ill. Rev. Stat. §5301 et seq., as amended or substituted); or

b) in a state where statutory licensure exists, a Clinical Psychologist who holds a valid credential for such practice; or

c) if practicing in a state where statutory licensure does not exist, a psychologist who specializes in the evaluation and treatment of Mental Illness and Chemical Dependency and who meets the following qualifications:

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

   2. is a Registered Clinical Psychologist with a graduate degree from a regionally accredited University or College and has not less than six

years experience as a psychologist with at least two years of supervised experience in health services.

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

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.

Respite Care Services .....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.

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.

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

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

Speech Therapy .....means treatment for the correction of a speech impairment, including pervasive developmental disorders.

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

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 the Plan.

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

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

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

CONTINUATION OF COVERAGE FOR DISABLED OR RETIRED PUBLIC EMPLOYEES

NOTE: The CONTINUATION OF COVERAGE FOR DISABLED OR RETIRED PUBLIC EMPLOYEES applies only to certain employers. See your employer or Group Administrator should you have any questions about this continuation provision.

Public employees and surviving spouses of such employees who are eligible for continued group health coverage under Sections 367 (g), (h) and (i) of the Illinois Insurance Code may continue their coverage under this Certificate subject to the following conditions:

1. The public employee or surviving spouse must be covered under this Certificate up to the date of eligibility for continued group health coverage. If such employee or spouse has Family Coverage, he may continue to have Family Coverage.
2. Group coverage can be continued until the public employee or surviving spouse is no longer eligible, as specified in Sections 367 (g), (h) and (i) of the Illinois Insurance Code, subject to all of the termination provisions of this Certificate (for example, termination of the Group's Policy or reaching the limiting age for dependent children). Coverage for a surviving spouse will end if such spouse should remarry. It is the employee/spouse's responsibility to inform the Plan of his loss of eligibility.
3. The total monthly premium for this continuation of coverage must be paid by the Group to the Plan, whether such premium is deducted from a pension payment or paid directly to the Group by the public employee or surviving spouse.
4. If the public employee or surviving spouse who is continuing coverage under this Certificate becomes eligible for Medicare, the benefits under this Certificate will be supplemental to the benefits provided under Medicare.
5. If the public employee or surviving spouse should choose to convert his or her group coverage to a "direct-payment" conversion policy, as described above under Conversion Privilege, such employee or spouse will no longer be eligible for this continuation of group coverage.

CONTINUATION OF COVERAGE FOR DISABLED OR RETIRED FIREMEN

NOTE: The CONTINUATION OF COVERAGE FOR DISABLED OR RETIRED FIREMEN applies only to certain employers. See your employer or Group Administrator should you have any questions about this continuation provision.

Firemen and surviving spouses of such firemen who are eligible for continued group health coverage under Section 367 (f) of the Illinois Insurance Code may continue their coverage under this Certificate subject to the following conditions:

1. The fireman or surviving spouse must be covered under this Certificate up to the date of eligibility for continued group health coverage. If such fireman or spouse has Family Coverage, he may continue to have Family Coverage.
2. Group coverage can be continued until the fireman or surviving spouse is no longer eligible, as specified in Section 367 (i) of the Illinois Insurance Code, subject to all of the termination provisions of this Certificate (for example, termination of the Group's Policy or reaching the limiting age for dependent children). Coverage for a surviving spouse will end if such spouse should remarry. It is the employee/spouse's responsibility to inform the Plan of his loss of eligibility.
3. The total monthly premium for this continuation of coverage must be paid by the Group to the Plan, whether such premium is deducted from a pension payment or paid directly to the Group by the fireman or surviving spouse.
4. If the fireman or surviving spouse who is continuing coverage under this Certificate becomes eligible for Medicare, the benefits under this Certificate will be supplemental to the benefits provided under Medicare.
5. If the fireman or surviving spouse should choose to convert his or her group coverage to a "direct-payment" conversion policy, as described above under Conversion Privilege, such fireman or spouse will no longer be eligible for this continuation of group coverage.

CONTINUATION OF COVERAGE FOR CERTAIN PUBLIC SAFETY EMPLOYEES

NOTE: The CONTINUATION OF COVERAGE FOR CERTAIN PUBLIC SAFETY EMPLOYEES applies only to certain employers. See your employer or Group Administrator should you have any questions about this continuation provision.

If you are a full-time law enforcement, correctional or correctional probation officer, or firefighter and are eligible for continued group health insurance under the Public Safety Employee Benefits Act (820 ILCS 320), you may maintain such group health insurance under the following conditions:

1. You and your eligible dependents must have been insured under this Certificate on the day immediately preceding the date of eligibility for continued group health insurance.
2. Your Group shall pay the entire premium of the group health insurance coverage for you, your spouse, and each dependent child until the child reaches the limiting age under this Certificate or until the end of the calendar year in which the child reaches the age of 25, if the child continues to be dependent for support, whichever is later.
3. If you subsequently die, your Group shall continue to pay the entire health insurance premium for your surviving spouse until he or she remarries and for your dependent children under the conditions established in 2. above.
4. Health insurance benefits under this Certificate shall be reduced by health insurance benefits payable from any other source.

BlueCross BlueShield of Illinois

Experience. Wellness. Everywhere.™

GB-16 HCSC
C10–953 12/10

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

APPENDIX A

Blue Cross Blue Shield

Additional Requirements
Additional Terms and Conditions

BLUE CROSS BLUE SHIELD

ADDITIONAL REQUIREMENTS AND ADDITONAL TERMS

	Provision	Confirm
1.	Your proposal has an effective date of coverage of December 1, 2011	Yes
2.	This RFP is not an offer to contract, but rather is an attempt to establish a common framework and process within which an agreement may be reached.	Yes
3.	Responses submitted by a Vendor to this RFP represent a firm offer to contract on the terms and conditions described in the Vendor's response and in the RFP. This RFP and the response to this RFP shall become part of the contract. Failure by any Vendor to comply with the specifications and requirements provided in this RFP may result in disqualification of such Vendor. Submission of a response to this RFP shall constitute Vendor's acknowledgment and acceptance of all of its provisions, including a warranty that such response and any contract negotiations will comply with all laws as well as judgments, orders, decrees or consent agreements with any governmental agency or court relating to the manufacture, promotion, advertising, marketing, sale or pricing of any product or service to be furnished to the client or its affiliates. If you wish to propose any changes in the language in this Request for Proposal, your requested changes must be included as a part of your Proposal. Changes should be made only as you deem necessary, i.e., only substantive changes that are appropriate to reflect the terms and conditions of your Proposal. You will not be permitted to request changes to the scope of your Proposal at a later date, other than to accommodate any mutually-agreed changes in the scope of your services. Please note, the fact that you may request a change to the requirements set forth in this Request for Proposal is no guarantee that such request will be accepted. Your requested change will be given appropriate consideration for inclusion in the Agreement and its related Scope of Services if you are chosen to provide the services contemplated herein.	Yes
4.	You will be bound by your proposal until the effective date of December 1, 2011 and up to six months thereafter, during which time Cook County may request clarification or correction of the proposal for the purpose of evaluation. Amendments or clarifications shall affect only that portion of the proposal so amended or clarified.	Yes
5.	At any time, Cook County may, in its absolute discretion, require that any or all of its documentation and materials be returned or destroyed by Vendor.	Yes
6.	All documentation and work product contained in your response shall become the exclusive property of Cook County, including without limitation all ideas, concepts, models, plans, designs, drawings, projections, specifications, computer programs and other items developed or compiled by Vendor specifically for this RFP, except only as may be specified in an agreement executed between Cook County and Vendor. Title to such work product shall be and remain vested in Cook County.	Yes
7.	Responding parties receiving this RFP shall not disclose to anyone, other than their employees directly involved in responding to this RFP, any information concerning this request or obtained through subsequent communications with the County. No information contained in this RFP shall be duplicated, used or disclosed without the prior written consent of the County.	Yes
8.	The County and its employees shall equally protect proprietary data contained in your response. All such proprietary information contained within your response must be clearly identified and marked.	Yes
9.	Should you decide against responding to this RFP, please ensure the complete destruction of all materials and information provided in or with this RFP or return them to the County contact person identified herein.	Yes

10.	Cook County encourages free and open competition among Vendors; therefore, each Vendor must guarantee that its quoted prices have been established without collusion with other Vendors or informed parties and without any effort to preclude Cook County or its affiliates from obtaining the lowest possible competitive price. Whenever possible, specifications, bid invitations and conditions are designed to accomplish this objective, consistent with the necessity to satisfy the needs of Cook County and the accomplishment of a sound economical operation.	Yes
11.	At no time shall Cook County be considered to be under any obligation or commitment to purchase any products or services from any Vendor to the RFP until after a contract has been signed. The award, if any, will be made to the Vendor whose overall proposal is determined to be the most advantageous to Cook County. Notwithstanding the foregoing, this RFP is only an informal solicitation of data and information, and is not intended nor should it be construed as formal competitive bidding pursuant to any statute, code, ordinance, rule or regulation.	Yes
12.	Upon receipt of the RFP and through the final selection by Cook County, you shall not engage in any conduct that would be seen as improperly influencing Cook County's decision. The exchange or offering of any money, gift item, personal service or unusual hospitality by either party is expressly prohibited. This prohibition is equally applicable to either party's officers, employees, agents or immediate family members. Failure to comply with this policy will disqualify a Vendor from participation.	Yes
13.	Neither Cook County nor Vendor shall discriminate in the provisions of the proposed products or services in connection with this RFP on the basis of age, race, color, national origin, religion, sex, sexual orientation, disability, qualified disabled veteran status, qualified veteran of the Vietnam era status, or any other category protected by law.	Yes
14.	Vendor shall be solely responsible for all costs and expenses incurred in the preparation and presentation of its response to this RFP, including without limitation market research and attendance at meetings.	Yes
15.	Any publicity, announcement or other disclosure regarding this RFP, Vendor's response or subsequent communications with Cook County may only be made with the prior written authorization of Cook County, which Cook County may withhold in its absolute discretion. Neither this RFP nor any subsequent contract shall confer on any Vendor the right to use the name "Cook County" or any of its subsidiary or affiliated companies (a) in any advertising, publicity or other disclosures, (b) to express or imply any endorsement of Vendor's products or services, or (c) for any other purpose or in any other manner.	Yes
16.	As a business associate of Cook County, as defined in the Administrative Simplification provisions of HIPAA, your organization is compliant with all required HIPAA privacy and security regulations. Also, your organization imposes the standards on any and all of your subcontractors. You authorize Cook County to terminate its contract with you if you violate any material term of the business associate contract.	Yes
17.	Your plan is in compliance with all HIPAA rules and regulations including nondiscrimination rules, security and electronic data interchange regulations, privacy regulation and prior coverage certification requirements. A HIPAA privacy and/or security audit may be performed by Cook County or an outside agency where applicable and without limit, at no additional charge. Cook County may select any person(s) or organization(s) to conduct an audit. The audit will be conducted in compliance with mutually agreed upon confidentiality requirements.	No
18.	By submitting a response to this RFP, your organization expressly acknowledges that patient data, business procedures, ideas, inventions, plans, financial data, contents of the RFP, and other information disclosed in this process are the sole and exclusive property of Cook County. You agree that you will safeguard such information to the same extent that you safeguard your own confidential material or data relating to your own business information that is of a confidential or proprietary nature. You agree that it will not disclose any of the information to any third party without the express written permission of Cook County.	Yes
17.	Your organization is licensed to provide the services requested in this RFP in all 50 states, plus Puerto Rico and all US territories.	Yes

18.	The proposed pricing excludes all finder's fees, or any other type of remuneration that is available to licensed brokers and agents. Commissions will be confirmed after the final bidder is selected, but should be excluded in your quote.	Yes
19.	Your proposal is not contingent upon being the only plan offered in the service area and does not include minimum participation or employer contribution requirements.	Yes
20.	Your plans will not include any actively-at-work or pre-existing condition exclusion clauses.	Yes
21.	Your plans will be offered to all eligible employees, as determined by Cook County	Yes
22.	Any individual who is covered by the current programs as of November 30, 2011 will be fully covered by the new vendors effective December 2011 on a no loss/no gain basis.	Yes
23.	The quoted fees are guaranteed from December 1, 2011 through November 30, 2012, and considered firm regardless of experience or actual enrollment as of the effective date.	Yes
24.	Proposed fees duplicate the scope of services and current and/or requested plan set forth in the bid forms. Any deviations from the current and/or requested scope of services or administration of the plan designs must be noted directly in the bid forms.	Yes
25.	All restrictions or deviations from these specifications (including plan design) are clearly stated in your response to the applicable bid forms; otherwise, it will be considered that your proposal complies with all the technical and financial requirements, and contract terms and conditions described in these specifications.	Yes
25.	If required under Department of Labor regulations section 2520.102-3, the Health Plan description will include, in non-English language, a notice offering assistance to plan participants in understanding the Health Plan as well as the procedures for obtaining such assistance. Your plan will provide such assistance to plan participants to give them a reasonable opportunity to become informed of their rights and obligations under the Health Plan.	Yes
26.	Plan participants will receive Summaries of Material Modifications (SMMs) or Summaries of Material Reductions (SMRs), as applicable, to inform them of changes in coverage, plan rules, etc. within ERISA-specified timeframe. With respect to any material changes in health benefits, your plan will notify Cook County and participants in advance of such reduction.	Yes
27.	Confirm that your plan is processing claims/appeals in accordance with the procedure rules for claims (Department of Labor regulations section 2560.503-1), effective for claims filed on or after 1/1/03. (The rules stipulate (a) accelerated timeframes for initial and appeal decisions, (b) accelerated and enhanced communications regarding decisions and appeals, (c) consultation with a medical professional for health and disability appeals, and (d) participation of decision-makers on an appeal different from those on the original decision.) In addition, plan descriptions (or SMMs distributed) will include the new claims/appeals procedure rules for claims filed on or after 1/1/03.	Yes
28.	Your plan will comply with all laws, ordinances, and regulations, applicable to the services contemplated herein. By responding to this RFP, you are stating that you are familiar with all federal, state, and local laws, ordinances, code rules, and regulations.	Yes
29.	Please confirm that you will issue the 1099-HC tax forms to Cook County's employees, and the special summary of 1099s to the Commonwealth of Massachussetts, on Cook County's behalf, by the required deadline, and at no charge, in accordance with enacted Massachusetts health care reform.	Yes
30.	Your plan will assist Cook County in meeting the requirements set forth by the City of San Francisco's Health Care Security Ordinance.	No
31.	You will allow Cook County to perform claim, customer service, clinical, and appeals audits, where applicable and without limit, at no additional charge, to be performed by Cook County or an outside agency. The right to audit includes, but is not limited to, the right to audit procedures, internal audits, computer systems, claim files, grievance records, and accounting records.Cook County may select any person(s) or organization(s) to conduct an audit. The audit will be conducted in compliance with mutually agreed upon confidentiality requirements.	No
32.	Data on Cook County's program and results will not be used by your organization without written consent from Cook County. Any breach of this requirement could lead to termination of the contract and legal action.	Yes
33.	Cook County will contract directly with your organization for services. Any outsourcing agreements are made solely between your organization and the organization providing services.	Yes
34.	Cook County has the right to terminate the agreement in the event of a change of ownership of the vendor.	Yes
35.	Your plan will notify Cook County of a contract termination no later than 240 days prior to the renewal date.	Yes

35.	Cook County can terminate your contract immediately with cause and with 30 days advance notice without cause. Cook County will notify you of any problems or concerns and give you adequate time to address any issues prior to exercising a "without cause" termination.	Yes
35.	Your plan will be the named fiduciary regarding review of claims and regarding appeals of Adverse Benefit Determinations (as the term is defined in ERISA). Your plan will be responsible for administering claims for benefits under the plan on a self insured basis. In discharging its responsibilities, your plan will act in accordance with the documents and instruments governing the plan, and any applicable federal or state law, including, without limitation, the procedures described in Section 503 of ERISA and regulations promulgated thereunder. Your plan will be the appropriate named fiduciary for the purpose of providing a participant who has an Adverse Benefit Determination with a full and fair review of the decision denying the claim. Your plan's decision on appeal of the Adverse Benefit Determination will be the final review for the plan. In exercising its fiduciary responsibility, your plan will have sole and complete discretionary authority to determine eligibility for benefits, to construe the terms of the plan, to make factual determinations, and to determine the validity of charges submitted for reimbursement under the plan. Your plan will be deemed to have properly exercised such authority unless it has abused its discretion hereunder by acting arbitrarily and capriciously. Notwithstanding the foregoing, the client will be the administrator of the plan, and will have sole and complete discretionary authority to determine questions relating to the eligibility of employees and dependents for participation in the plan, including determination of who is a participant. Nothing in the Contract will limit the ability of the client to amend or terminate the plan.	Yes
36.	Vendor agrees to maintain complete records of all claims and payments for a minimum of six years or greater as required by law. At the end of the six-year period, records shall either be transferred to Cook County or destroyed under Cook County direction.	Yes
37.	Vendor agrees to provide necessary data files to respond to government requests or to respond to class action lawsuits free of charge for the length of the contract. Such services shall be provided at the Cook County custom reporting rate after the contract has terminated.	Yes
38.	Any planned change in the account team personnel will be communicated to Cook County by phone and in writing at least 14 calendar days prior to the effective date, including reason for the personnel change.	Yes
39.	Your organization reviews system access on a periodic basis to ensure proper maintenance procedures are in effect (e.g. terminated users no longer have system access, only senior staff are given sensitive systems access and no one person is given inappropriate combinations of system access).	Yes
40.	Your proposal is binding and the typed name in the field to the right serves as signature for confirmation of the scope of services.	Yes

Dear Incumbent Vendor,

As the follow up to the recent finalist meeting, the County had internal discussions and is requesting your confirmation to meeting the following terms and conditions prior to finalizing the FY2012 contract.

Please review and complete the table below by September 9, 2011 and return to the County (lisa.walik@cookcountyil.gov, elvia.fernandez@cookcountyil.gov) with a copy to Mercer (jeff.black@mercer.com, ken.maginot@mercer.com, agnieszka.dyna@mercer.com)

Terms and Conditions	Confirmation (Agree, Partially agree – please comment, Disagree)
PHARMACY DATA INTEGRATION	
▪ Integrate CVS Caremark data at no cost (written commitment provided following the finalist meeting) by Oct 31, 2011	Agree
MEDICAL RENEWAL	
▪ Guarantee FY13 renewal medical trend factor not to exceed 7.2% (PPO and non capitated HMO claims)	Disagree – BCBSIL will not guarantee future renewal trend factors.
▪ Guarantee the physician capitation component of the HMO renewals not to exceed an increase of 7.2%	Partially Agree - BCBSIL will guarantee physician capitation component of the HMO renewals not to exceed an increase of 8.5%.
▪ Guarantee retention for FY14 not to exceed 5% increase of FY13 retention components (on a per employee per month basis)	Agree
GUARANTEES	
▪ Confirm current account managers time commitment to County; enhance account service team to better meet County's day to day needs	Agree - Account Manager will be dedicated to Cook County an average of 40 business hours per month.
▪ Clarify time commitment for County-specific reporting consultant including frequency, quantity and level of customization available when providing County with requested reports	Agree - - Reporting Consultant will be available as needed depending on volume/frequency of report request and can be available as frequently as monthly.
▪ Clarify time commitment for County-specific wellness consultant,	Agree - - Wellness Consultant will be

Terms and Conditions	Confirmation (Agree, Partially agree – please comment, Disagree)
client reporting consultant and clinical account executive	available as needed depending on volume/frequency of report request and can be available as frequently as monthly.
▪ Agree to provide regular updates to the County with regards to any upcoming pilots, innovations to the programs (please clarify frequency of providing such updates)	Agree - Updates will be provided when any new pilots are introduced or upcoming innovations. Frequency will be subject to when enhancements are announced.
▪ Add a guarantee for BCBSIL responses to client queries within 24 hours	Agree – BCBSIL agrees to 24 hour turnaround time on response to client inquires, however, some inquiries may be more complex and need additional time to resolve.
▪ Provide new "pay for performance" metrics (total of 15% per year) specific to each calendar year	Agree - We have agree to put 20% of admin charge at risk for our medical service performance guarantees. We can incorporate a customer satisfaction component and Cook County will have the flexibility to allocate the 20% across these categories with a maximum of 2% on a specific category. The medical services performance guarantee percentage at risk do apply against total admin charges, however, the additional 30% at risk for medical management items represent a percentage of the Blue Care Connections (BCC) fees.
▪ Conduct quarterly vendor/client review meetings to identify opportunities and review data reporting (detailed claim cost	Agree - Subject to mutually on-going dialogue with expanded quarterly

Terms and Conditions	Confirmation (Agree, Partially agree – please comment, Disagree)
saving experience)	meetings.
▪ Clinical account team meets at least twice per year with County	Yes
▪ Significantly improve reporting services (provide cuts by union, include Rx data, clinical data, connect BlueCare Connections with BlueInsight, report on gaps in care program and network utilization); detail what your organization will provide	Partially Agree - Will provide reporting as mentioned but will be subject to account structure changes to capture union specific data.
WELLNESS	
▪ Program – Implement enhanced Lifestyle Management and Disease Management programs (asap) to maximize identification and participation – Advise on recommended actions to improve HRA participation – Work with County to investigate value-based design options for diabetes and/or cardiac – Achieve more outreach to members including enhanced processes for identifying participants, engaging participants in programs and measuring results	Agree – We agree to offer our comprehensive lifestyle and disease management programs with efforts to improve over time. Agree – Will advise by 12/31. Agree – Will begin in Dec Agree – Will begin in Dec
▪ Resources/Funding – Arrange for a dedicated wellness consultant to help manage the program – Fund a clinical and wellness audit every other year ($50,000) – Increase annual communication budget to $200k per year for wellness programs – Increase current $75,000 wellness fund to $200,000 per year	Agree - Available as needed and will provide contact information in December. BCBSIL cannot commit to this funding on a client specific basis. Agree – BCBS agrees to $75,000 communication budget per terms of RFP. Agree - BCBSIL agrees to a $75,000 Wellness fund per terms of RFP.
▪ Communication	

Terms and Conditions	Confirmation (Agree, Partially agree – please comment, Disagree)
– Provide tailored communication to members focusing on Wellness	Agree
– Arrange four free Health Fairs a year at County; organized with other Cook County vendors	Continue to support up to four County Health Fairs.

EXHIBIT 2

Schedule of Compensation

BLUE CROSS BLUE SHIELD

HEALTH INSURANCE RATES

FY12

	HMO IL
SINGLE	$ 465.88
EE + 1	$ 915.83
FAMILY	$ 1,288.25
	CLASSIC BLUE
SINGLE	$ 435.50
EE + 1	$ 881.88
FAMILY	$ 1,248.88
	BCBS PPO
SINGLE	$ 560.51
EE + 1	$ 1,102.18
FAMILY	$ 1,550.72

FEES FOR FISCAL YEAR 2013, FISCAL YEAR 2014 AND ANY RENEWY OPTION WILL BE RENEGOTIATED ANNUALLY.

ASC COSTS

DPPO	Current Enrollment	Fully-insured Retention PEPM	ASO Fee PEPM
PPO	5,914	$43.00	$45.19
CLASSIC BLUE	3,017	$23.86	$23.25

EXHIBIT 3

Evidence of Insurance

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY) 01/10/2011

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

PRODUCER
MARSH USA INC.
500 WEST MONROE STREET
CHICAGO, IL 60661

J05515---10-11

CONTACT NAME:
PHONE (A/C, No, Ext):
FAX (A/C, No):
E-MAIL ADDRESS:
PRODUCER CUSTOMER ID #:

INSURED
HEALTH CARE SERVICE CORPORATION
AND ITS SUBSIDIARIES
300 EAST RANDOLPH STREET
CHICAGO, IL 60601

INSURER(S) AFFORDING COVERAGE		NAIC #
INSURER A :	Zurich American Insurance Co	16535
INSURER B :	N/A	N/A
INSURER C :	Safety National Casualty Corp.	15105
INSURER D :	N/A	N/A
INSURER E :	American Zurich Insurance Company	40142
INSURER F :		

COVERAGES **CERTIFICATE NUMBER:** CHI-003060911-43 **REVISION NUMBER:** 7

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSR	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
A	GENERAL LIABILITY			GLO9377127-07 (AOS)	11/01/2010	11/01/2011	EACH OCCURRENCE	$ 2,000,000
A	[X] COMMERCIAL GENERAL LIABILITY			GLO9141215-04 Randolph	11/01/2010	11/01/2011	DAMAGE TO RENTED PREMISES (Ea occurrence)	$ 1,000,000
	[ ] CLAIMS-MADE [X] OCCUR						MED EXP (Any one person)	$ 10,000
							PERSONAL & ADV INJURY	$ 2,000,000
							GENERAL AGGREGATE	$ 2,000,000
	GEN'L AGGREGATE LIMIT APPLIES PER:						PRODUCTS - COMP/OP AGG	$ 2,000,000
	[X] POLICY [ ] PRO-JECT [ ] LOC							$
	AUTOMOBILE LIABILITY						COMBINED SINGLE LIMIT (Ea accident)	$
	[ ] ANY AUTO						BODILY INJURY (Per person)	$
	[ ] ALL OWNED AUTOS						BODILY INJURY (Per accident)	$
	[ ] SCHEDULED AUTOS						PROPERTY DAMAGE (Per accident)	$
	[ ] HIRED AUTOS							$
	[ ] NON-OWNED AUTOS							$
	[ ] UMBRELLA LIAB [ ] OCCUR						EACH OCCURRENCE	$
	[ ] EXCESS LIAB [ ] CLAIMS-MADE						AGGREGATE	$
	[ ] DEDUCTIBLE							$
	[ ] RETENTION $							$
E	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY			WC9377128-07 (AOS)	11/01/2010	11/01/2011	[X] WC STATU-TORY LIMITS [ ] OTH-ER	
A	ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) Y/N [N]	N/A		WC9377129-07 (RETRO)	11/01/2010	11/01/2011	E.L. EACH ACCIDENT	$ 1,000,000
	If yes, describe under DESCRIPTION OF OPERATIONS below						E.L. DISEASE - EA EMPLOYEE	$ 1,000,000
							E.L. DISEASE - POLICY LIMIT	$ 1,000,000
C	IL-EXCESS WC			SP-4042905 "SIR: $400,000"	01/01/2011	11/01/2012	WORKER COMP: STATUTORY EMPL. LIAB.	$1,000,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (Attach ACORD 101, Additional Remarks Schedule, if more space is required)
THE DISTRICT, ITS COMMISSIONERS, OFFICERS, AGENTS AND EMPLOYEES ARE INCLUDED AS ADDITIONAL INSURED UNDER THE GENERAL LIABILITY POLICY AS THEIR INTEREST MAY APPEAR, BUT ONLY TO THE EXTENT SUCH STATUS IS REQUIRE UNDER THEIR WRITTEN CONTRACT / AGREEMENT WITH THE NAMED INSURED.

CERTIFICATE HOLDER

METROPOLITAN WATER RECLAMATION DISTRICT
OF GREATER CHICAGO
100 EAST ERIE STREET
CHICAGO, IL 60611

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

AUTHORIZED REPRESENTATIVE
of Marsh USA Inc.

Katey E. Jones

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ADDITIONAL INFORMATION

CHI-003060911-43

DATE (MM/DD/YY)
01/10/2011

PRODUCER
MARSH USA INC.
500 WEST MONROE STREET
CHICAGO, IL 60661

J05515--10-11

INSURERS AFFORDING COVERAGE | **NAIC #**

INSURED
HEALTH CARE SERVICE CORPORATION
AND ITS SUBSIDIARIES
300 EAST RANDOLPH STREET
CHICAGO, IL 60601

INSURER G:	
INSURER H:	
INSURER I:	
INSURER J:	

TEXT

DARWIN SELECT INSURANCE COMPANY
MANAGED CARE PROFESSIONAL LIABILITY
POLICY NUMBER: 0303-3250
POLICY DATE: 01/01/2011 - 01/01/2012
LIMIT: $5,000,000

CERTIFICATE HOLDER

METROPOLITAN WATER RECLAMATION DISTRICT
OF GREATER CHICAGO
100 EAST ERIE STREET
CHICAGO, IL 60611

AUTHORIZED REPRESENTATIVE
of Marsh USA Inc.
Katey E. Jones

EXHIBIT 4

Board Authorization

POST BOARD AGENDA

APPROVED
BY THE BOARD OF COOK COUNTY COMMISSIONERS
JAN 18 2012

BUREAU OF FINANCE
OFFICE OF THE PURCHASING AGENT

REQUEST TO AMEND PREVIOUSLY APPROVED CONTRACTS

Transmitting a Communication, dated November 29, 2011 from

MARIA DE LOURDES COSS, Chief Procurement Officer
and
LISA M. WALIK, Director, Department of Risk Management

requesting authorization for the Cook County Board of Commissioners to approve as amended (Comm. No. 313903), which was previously approved on the September 7, 2011 Board Agenda in the Finance Committee Report of September 7, 2011.

The amendment is indicated by the underscored and stricken language.

Transmitting a Communication, dated July 26, 2011 from

LISA M. WALIK, Director, Department of Risk Management

requesting authorization for the ~~Purchasing Agent~~ Chief Procurement Officer to enter into and execute a contract with Health Care Service Corporation, Chicago, Illinois for health insurance benefits.

Reason: To provide the eligible Cook County employees and their dependents with health care benefits (PPO and HMO) for a period of (2) two years with two one-year renewal options. A Request for Qualifications ("RFQ") was downloaded by thirty-three (33) companies and four (4) companies responded to the RFQ. In accordance with the procurement process, each of the responses were reviewed and each respondent was deemed qualified. A Request for Proposal was subsequently issued this past spring to the qualified respondents. Based upon the initial analysis of the proposals submitted, three companies were selected as finalists and Health Care Service Corporation was recommended for a contract award.

Estimated Fiscal Impact: $262,000,000* Contract period: December 1, 2011 through November 30, 2013. Department Number: 542-176 (Health Insurance).

*The estimated fiscal impact is based on current enrollment and the plan design that is currently in force. The plan design and costs are subject to change based on the outcome of future labor negotiations. Therefore, the fiscal impact is subject to change accordingly. Based on these factors, sufficient funds will be budgeted for each fiscal year.

Approval for this item would commit Fiscal Years 2012 and 2013 funds.

No lobbying contact was made for this item.

Contract period: December 1, 2011 through November 30, 2013. (542-177 Dental Insurance Account).

Approval for this item would commit Fiscal Years 2012 and 2013 funds.

No lobbying contact was made for this item.