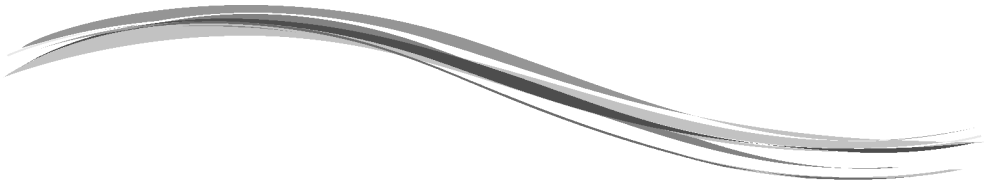
Your Health Care Benefit Program



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A Blue Cross HMO

a product of

Blue Cross and Blue Shield of Illinois

BlueCross BlueShield of Illinois

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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,

Karen Atwood

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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	$10 per Visit
— Your Cost for Outpatient Specialist Physician Visits	$10 per Visit
— Your Cost for Outpatient Office Visits for Periodic Health Examinations or Routine Pediatric Care	$10 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 Provider's Charge
— Limit on Number of Outpatient Rehabilitative Therapy Treatments	60 Treatments 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 Provider's Charge
— 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	$50 Emergency Room Copayment (waived if admitted to Hospital as an Inpatient immediately following emergency treatment)
— Your Cost for an Out-of-Area Emergency	$50 Emergency Room Copayment (waived if admitted to Hospital as an Inpatient immediately following emergency treatment)
— Your Cost for Emergency Ambulance Transportation	None

CHEMICAL DEPENDENCY TREATMENT BENEFITS

— Your Cost for Inpatient Chemical Dependency Treatment	None
— Your Cost for Outpatient Office Visits for Chemical Dependency Treatment	$10 per Visit
— Your Cost for Outpatient Specialist Physician Visits for Chemical Dependency Treatment	$10 per Visit

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

OUTPATIENT PRESCRIPTION DRUG PROGRAM BENEFITS

— Your Cost for Prescription Drugs and Diabetic Supplies Purchased from a Prescription Drug Provider Participating in the **34-Day Supply** Prescription Drug Program:

— Generic Drugs, insulin and insulin syringes	$10 per Prescription
— Formulary Brand-name Drugs	$20 per Prescription
— Non-Formulary Brand-name Drugs	$35 per Prescription
— Self-Injectable Drugs other than Insulin and Infertility Drugs	$50 per Prescription
— Diabetic Supplies	None

— Your Cost for Prescription Drugs and Diabetic Supplies Purchased from a Prescription Drug Provider Not Participating in the **34-Day Supply** Prescription Drug Program:

  — For drugs or diabetic supplies purchased within Illinois:

    No benefits will be provided for drugs or diabetic supplies purchased from a Non-Participating Prescription Drug Provider.

  — For drugs or diabetic supplies purchased outside Illinois:

    The appropriate Copayment(s) or Coinsurance indicated above plus any difference between the Participating Provider's Charge and the Non-Participating Provider's Charge for drugs prescribed for emergency conditions.

— Your Cost for Prescription Drugs and Diabetic Supplies Purchased from a Prescription Drug Provider Participating in the **90-Day Supply** Prescription Drug Program:

— Generic Drugs, insulin and insulin syringes	$20 per Prescription
— Formulary Brand-name Drugs	$40 per Prescription
— Non-Formulary Brand-name Drugs	$70 per Prescription
— Self-Injectable Drugs other than Insulin and Infertility Drugs	$50 per Prescription
— Diabetic Supplies	None

— Your Cost for Prescription Drugs and Diabetic Supplies Purchased from a Prescription Drug Provider Not Participating in the **90-Day Supply** Prescription Drug Program:

  — No benefits will be provided for drugs or diabetic supplies purchased from a Prescription Drug Provider not participating in the 90-day supply program.

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ELIGIBILITY

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

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

REPLACEMENT OF DISCONTINUED GROUP COVERAGE

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

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

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

INDIVIDUAL COVERAGE

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

FAMILY COVERAGE

Under Family Coverage, your health care expenses and those of your enrolled spouse and your (and/or your spouse's) unmarried children who are under the limiting age specified in the BENEFIT HIGHLIGHTS section will be covered. All of the provisions of this Certificate that pertain to a spouse also apply to a party of a Civil Union unless specifically noted otherwise. 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 period for which premium has been accepted.

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