BlueCross BlueShield of Nebraska

A Member of the Blue Cross and Blue Shield Association, an Association of Independent Blue Cross and Blue Shield Plans

TempCare Contract

Blue Cross and Blue Shield of Nebraska is a mutual insurance company, licensed by the State of Nebraska.

This Contract of insurance consists of the Application, this document, your Schedule of Benefits, and any attachments or endorsements thereto.

Starting at 12:01 a.m., at your principal place of residence, on the effective date stated in the Application, and in consideration of the attached Application and payment of premiums as provided therein, Blue Cross and Blue Shield of Nebraska agrees to make payment for the services described, defined and limited herein, during the term of this Contract.

This Contract will be renewed each month when you pay your premium for a maximum of twelve months. We may cancel this Contract if you fail to pay your premium, or for the other reasons stated in Part III.C.

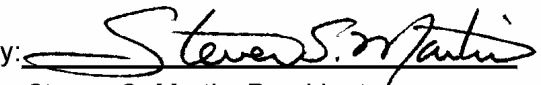
Please read this Contract carefully. If after reading this Contract you are not satisfied for any reason, please return it to us within ten (10) days of its delivery to you. We will send you back your premium. This Contract will then be void.

Only an Officer of Blue Cross and Blue Shield of Nebraska can approve a change to this Contract and that change must be in writing. No agent may change this Contract in any way. Any change will affect all Covered Persons.

This Contract is made in and governed by the laws of the State of Nebraska.

Throughout this Contract, Blue Cross and Blue Shield of Nebraska will be referred to by the personal pronouns "we," "our," and "us." The person making application will be referred to by the personal pronouns "you" or "your".

BLUE CROSS AND BLUE SHIELD OF NEBRASKA

By: 

Steven S. Martin, President
and Chief Executive Officer

ENDORSEMENT ENCLOSED

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PART I. ELIGIBILITY, EFFECTIVE DATE OF COVERAGE

A. ELIGIBILITY: To be eligible for this Contract, you must meet the following requirements:

1. You must be, and remain, a resident of the State of Nebraska.

If you move from the State of Nebraska, we may terminate your coverage. If we terminate your coverage under these circumstances, we will provide you with thirty (30) days written notice, mailed to you as provided in Part III.C.

2. You must complete your Application truthfully. If you do not complete your Application truthfully, and we discover that fact, we may rescind your coverage or the coverage of the person about whom the misstatement was made. If we rescind your coverage, you or your dependents will not be eligible for any of the benefits provided by this Contract. If we rescind your Contract, we will refund the premiums you have paid, less any benefits we may have paid in error.

3. You may select one of the following Membership Units:

Single Membership: Membership option providing benefits for Covered Services provided to you only.

Family Membership: Membership option providing benefits for Covered Services provided to you and your Eligible Dependents.

Single Parent Membership: Membership option providing benefits for Covered Services provided to you and your Eligible Dependents, but not to your spouse.

4. You pay the premium for the first billing period, and enrollment fee.

5. You must not be eligible for any other employer group coverage or Medicare.

B. EFFECTIVE DATE OF COVERAGE: Upon acceptance by us of your Application, and any applicable fees and premium, coverage hereunder, except for Pre-existing Conditions, shall commence as follows:

1. Coverage for you and any Eligible Dependents if you have elected Family or Single Parent Membership shall begin the first day of the month following the date of your Application.

2. Coverage, including the necessary care and treatment of congenital defects and birth abnormalities, shall begin at birth for children of a Member with a Family Membership or Single Parent Membership born after the effective date of this Contract.

3. If you or an Eligible Dependent are hospitalized on the date this Contract is transferred to another Blue Cross and Blue Shield of Nebraska Contract, the Hospital benefits for that admission will be provided under this Contract.

4. Coverage under this Contract for any person confined in a Hospital, convalescent hospital, or place of treatment for Mental illness, drug addiction, or alcoholism, on their initial effective date, shall not begin until 12:01 A.M. on the day after dismissal therefrom. If this Contract replaces another Contract with us, benefits for Covered Services furnished by this Contract shall not begin until the Covered Person is discharged from the Hospital.

5. No benefit payment will be made for Covered Services provided to a Covered Person for a Pre-existing Condition, Pregnancy, or a Congenital Anomaly existing at the time this Contract comes into effect.

Pre-existing Condition is defined as an Illness or Injury for which a Physician prescribed medication or rendered medical treatment or advice within 12 months prior to the effective date of coverage. A Pre-existing Condition is also defined as an Illness which exhibited symptoms within 12 months prior to the effective date of coverage or a previous Injury which exhibited symptoms or complications within 12 months prior to the effective date of coverage, either of which would lead a prudent person to seek medical treatment or advice.

Congenital Anomaly is defined as a condition existing at or from birth which is a deviation from the norm such as clefting, protruding ears, birthmarks, webbed fingers or toes, and other conditions normally considered birth defects.

PART II. CHARGES FOR COVERAGE

A. The charges for this coverage are called premiums. Premiums are payable in advance at our home office in Omaha, Nebraska. This Contract will be renewed each month when you pay your premium, up to a maximum of twelve (12) months, unless canceled pursuant to Part III.C.

B. The premium is based on your sex and age and whether you choose a Single, Single Parent, or Family Membership.

C. We will refund any premium paid if you provide us with proof in writing that such premium was collected as the result of our error.

PART III. GRACE PERIODS; REINSTATEMENT; CANCELLATION; TERMINATION

A. GRACE PERIOD: A grace period of ten (10) days for monthly premiums, interest free, will be allowed. If you make payment during that period, this Contract will continue to be in force.

B. REINSTATEMENT: If any renewal premium is not paid within the time granted for payment, our later acceptance of premium shall reinstate the Contract; provided, that if we require an application for reinstatement and we issue a conditional receipt for the premium paid, the coverage will be reinstated upon our approval of such application or, lacking such approval, upon the 45th day following the date of such conditional receipt unless we have previously notified you, in writing, of our disapproval of such application. The reinstated coverage shall include only loss resulting from such Injury as may be sustained after the date of reinstatement and loss due to such Illness as may begin more than ten (10) days after such date. In all other respects, the parties shall have the same rights hereunder as they had immediately before the due date of the defaulted premium, subject to any provisions endorsed herein, or attached hereto. Any premium accepted in connection with reinstatement shall be applied to a period for which a premium has not been previously paid, but not to any period more than sixty (60) days prior to reinstatement.

C. CANCELLATION: We will cancel this Contract for any of the following reasons:

1. If you fail to pay premiums;

2. If you, or someone acting on your behalf, or acting under your Membership, commits fraud or an act of misrepresentation, or if you fail to comply with the requirements of Part XII, Subrogation;

3. If you no longer meet eligibility requirements;

4. If you become eligible for Medicare;

5. If we cancel all contracts of the same class;

6. After your coverage has been in effect for twelve (12) months.

We will provide written notice of cancellation to you by certified or registered mail at your last-known address as shown by our records at least thirty (30) days prior to the effective date of cancellation, except in those cases where cancellation is due to the failure to pay premiums, or in cases of fraud or misrepresentation. Subject to paragraph A, Grace Period, above, cancellation for failure to pay premiums shall be effective as of midnight the last day for which the premium has been paid. In cases of fraud or misrepresentation, coverage shall be canceled upon the date notice is given, or any later date designated therein. If this Contract is canceled, cancellation shall be without prejudice to any claim originating prior to the effective date of cancellation.

D. TERMINATION: You may terminate this Contract by notifying us in writing. Following such notification, the Contract shall end at the end of the period for which premiums have been paid. If this Contract is terminated by you, no notice of cancellation will be given by us. If you specify an earlier termination date, or that coverage is to be terminated when we receive the notification of termination, the earlier date of termination will be effective. Coverage may not, however, be terminated in this manner on a date earlier than the receipt by us of notification. In the event of termination by you, we will return the prorated unearned premium to you. Termination shall be without prejudice to any claim originating prior to the effective date of termination.

PART IV. BENEFITS OVERVIEW

A. PAYMENT FOR SERVICES: This Contract provides benefits for Covered Services provided to Covered Persons except as stated in Part X, Exclusions and Limitations. The amount of benefit payment is determined by the following guidelines:

1. Payment for Covered Services provided by Physicians, Dentists, Physical Therapists, Nurses, or other professional providers of health care are limited to the Maximum Benefit Amount for such services. All benefit payments will be reduced by the applicable Deductible Amount stated in your Application, and the Coinsurance percentage stated in Part IV.C. You are responsible for payment of the Deductible, the Coinsurance, and for any Non-Covered Services.

We have contracted with many Physicians, Dentists, and other health care providers. These providers are called Participating Providers. A Participating Provider has agreed to accept your Deductible and Coinsurance payment, plus our benefit payment up to the total of the Maximum Benefit Amount, as payment in full for his or her charge.

If your services are provided by someone who is not a Participating Provider, you will also be responsible for any charge over the Maximum Benefit Amount. Benefit payment to a person who is not a Participating Provider will not exceed the benefit amount paid to a Participating Provider for the same Covered Services.

2. Payments will be made for Covered Services provided by Hospitals to Covered Persons. Our payment will be reduced by the applicable Deductible Amount stated in your Application, and the Coinsurance percentage stated in Part IV.C. You are responsible for payment of the Deductible, the Coinsurance and for any Non-Covered Services.

We have contracted with many Hospitals for Covered Services. These Hospitals are called Participating Hospitals. These hospital contracts provide a method for benefit payment. Most of the larger Hospitals are reimbursed based on a schedule of Diagnostic Related Groups (DRGs). The amount paid for a DRG is based upon the diagnosis and the procedure. The Participating Hospitals who are not reimbursed based on a DRG are reimbursed based upon their billed charges. For procedures where no DRG has been established, a Participating Hospital, on the DRG system, would be reimbursed based upon billed charges. A Participating Hospital has agreed to accept your Deductible and Coinsurance payment, plus your benefit payment up to the DRG amount, as payment in full.

3. Utilization Review: Covered Services provided by Hospitals, Physicians and all other health care providers are subject to our Utilization Review. Utilization Review is the evaluation by us of the use of a medical, diagnostic, or surgical procedure or service or the utilization of medical supplies, drugs or Durable Medical Equipment compared with established criteria in order to determine benefits. Benefits may be excluded for services, procedures, supplies, drugs or Durable Medical Equipment found by us to be not Medically Necessary, to be Investigative, to be for cosmetic purposes, or to be obsolete. Participating Hospitals have agreed that you will not be responsible for the charges for services which are determined to be non-payable by our Utilization Review programs. If benefits for a service at a Non-Participating Hospital are denied by Utilization Review, you will be responsible for payment of the charge.

4. EXCEPTION-OTHER INSURANCE: The above limits on payment requirements are subject to the following exception. If a Covered Person has other health and accident insurance, and the amount of the billed charges by the Provider is in excess of the amount payable under this Contract, the Covered Person may be responsible for an additional payment. If the benefit payable by the other insurance exceeds the Deductible, the Coinsurance and the Non-Covered Services, the Covered Person would be responsible for up to the total amount of billed charges, less our benefit payment to the extent benefits are payable by the other insurance.

5. We reserve the right to contract further with health care providers, and to alter benefit payment procedures to Participating Providers. Benefit payments to providers may be calculated on a charge basis, a per diem basis, a global fee basis, a capitated basis, a relative value scale, or in any other manner agreed upon between us and the provider. We agree, however, that any payment method agreed to between us and the providers will not affect the method of calculating your Deductible or Coinsurance.

6. All payments for Covered Services provided by Participating Hospitals, Participating Physicians or any other Participating Providers, shall be made directly to such providers. In all other cases, payments shall, at our option, be made either to you or your estate. No assignment, whether made before or after services are provided, of any amount payable according to this Contract shall be recognized or accepted by, or binding, upon us.

7. All benefits payable under this Contract shall be paid as soon as possible after the claim has been filed.

8. Extra-Contractual Benefits: We may expand the scope of benefits in an individual case to include payment for specific services which would not ordinarily be Covered Services if it appears to us that use of such services will reduce costs or improve the quality of care. We shall advise the Covered Person and the provider in writing when, and to what extent, payment for such services will be made. Such expansion of the scope of benefits shall not constitute an amendment to this Contract.

B. DEDUCTIBLE:

1. A Covered Person's Deductible Amount for a calendar year will be met when Allowable Charges for Covered Services incurred in that calendar year equal the Deductible Amount stated in the Application. The calendar year begins on the effective date of coverage and ends on December 31 of that same year.

2. The Deductible Amount must be met each calendar year for each Covered Person. Where coverage is provided by a Family or Single Parent Membership, however, the maximum Deductible Amount for the family is limited to twice the Deductible Amount per calendar year. No further Deductible Amounts will be applied that calendar year under the Membership.

3. If the total charges for Covered Services in a calendar year are less than the required Deductible Amount, such charges incurred during October, November, and December of that year may be carried over and applied against the Deductible Amount for the next calendar year.

C. COINSURANCE: Coinsurance is the amount of each Allowable Charge which the Covered Person must pay. This amount is computed as a percentage of the Allowable Charge less any unpaid Deductible. The percentage the Covered Person must pay as Coinsurance under this Contract is 20%.

D. COVERED PERSON'S LIABILITY LIMIT--THE STOP LOSS:

1. This Contract contains a Stop Loss. A Covered Person's Stop Loss is the total, during each calendar year, of the Covered Person's Coinsurance payment amounts under any part of the Contract.

2. When a Covered Person's Coinsurance payment equals $1,000, we will provide benefits for all Covered Services under this Contract without further application of the Coinsurance percentage during that calendar year, up to the Lifetime Maximum Benefit. Where coverage is provided by a Family or Single Parent Membership, however, the maximum Coinsurance amount for the family is limited to twice the Coinsurance amount ($2,000) per calendar year.

3. The Stop Loss applies to Covered Services provided by both Participating Providers and Non-Participating Providers. This provision does not apply to amounts paid by the Covered Person for services for which this Contract does not provide benefits; nor, does it include such amounts paid by the Covered Person if we have determined that the services are not Medically Necessary or otherwise non-payable pursuant to our Utilization Review Program, nor for charges in excess of the Maximum Benefit Amount.

E. TOTAL BENEFITS:

1. The total benefits payable for each Covered Person for the treatment of all conditions is $1,000,000.

2. The total benefits referred to herein apply to amounts paid under this Contract and to all benefits subject to maximums paid by us under any prior coverage.

F. In exchange for waiving physical examinations of Covered Persons and as a prerequisite to approval of claims, we shall be entitled to receive from all providers of Covered Services such facts, records, and reports about the examination or treatment of Covered Persons as we may need to process such claims. We shall hold such information confidential.

G. Payment by us for a specific service shall not make us liable for further payment for the same condition.

H. We may recover payments made in error as provided by law. Such excess payments not recovered shall be considered as benefits paid under this Contract.

I. Independent Contractors: Participating Providers provide Covered Services under the terms of this Contract as independent practitioners of the healing arts. Such providers are not our employees or agents. We will not be liable for any act, error or neglect of any Hospital, Physician or other provider or their agent.

PART V. BENEFITS FOR HOSPITAL SERVICES

A. OVERVIEW: Admission to a Hospital and all services must be ordered by a Physician. The following Hospital Services are Covered Services under this Contract. This means that, subject to the Exclusions and Limitations set forth in Part X, including determinations made by our Utilization Review Program, benefits will be provided for these services when provided to a Covered Person.

B. COVERED HOSPITAL INPATIENT SERVICES: Benefits will be paid for the following Covered Services:

1. Hospital Room:

a. Benefits will be provided for Hospital room and board. We will consider any special diet, and all nursing services included in the Hospital room charge. Benefits will be based upon the amount charged for a semiprivate room. If an intensive care, cardiac care or similar type of room is Medically Necessary, benefits will be based upon the charge for such room. When a Covered Person is confined to a private room, benefits shall be based upon the average charge for 2-bed accommodations in that Hospital, unless the patient is confined to a private (isolation) room to prevent contagion and we determine that isolation is Medically Necessary.

2. Use of operating, cystoscopic, cast, recovery and other surgical treatment rooms and equipment.

3. Anesthetics and their administration when performed by a Hospital employee.

4. Respiratory care including oxygen, administered by a certified respiratory therapist who is a Hospital employee.

5. Drugs, intravenous solutions, vaccines, biologicals, and medicines which are prescribed for and administered to the Covered Person while hospitalized.

6. Administration of intravenous solutions, blood, blood plasma, blood derivatives, or blood fractionates.

7. Supplies, materials and equipment, including dressings, splints and plaster casts, except "take-home" supplies and convenience items.

8. Radiology and pathology services when billed by the Hospital.

9. Physical therapy when provided by a licensed physical therapist, or other qualified person, as an employee of the hospital, if related to the primary condition for which hospitalized.

10. Occupational therapy consisting of range of motion exercises, strengthening exercises and prosthetic training to achieve pain relief, restoration of function, the prevention of disability or further deterioration for the following conditions:

Hand and upper extremity injuries;

Joint dysfunction resulting from arthritis;

Post mastectomy;

Burn care;

Amputation.

Such services must be provided by a licensed occupational therapist or licensed occupational therapist assistant, who is an employee of the Hospital.

Benefits shall not be provided for any other occupational therapy services including, but not limited to:

Training to compensate for perceptual impairment;

Teaching and practicing the activities of daily living;

Developing prevocational capacity.

11. Speech therapy when provided by a licensed speech-language pathologist or person practicing under the direct supervision of a licensed speech-language pathologist, if related to the primary condition for hospitalization.

C. COVERED HOSPITAL OUTPATIENT SERVICES AND FREE-STANDING AMBULATORY SERVICES

1. Payment will be made for Outpatient Hospital services or services provided by a Free-Standing Ambulatory Facility as identified in section B., paragraphs 2 through 11, above. For such services to be payable, they must be, in our opinion, Medically Necessary for the specific conditions being treated.

2. Payment will be made for a postoperative holding room charge, not to exceed the average cost of a semiprivate room in Nebraska for a period of one day.

3. Payment will be made for radiology and pathology services if provided within seventy-two (72) hours before an Inpatient Admission for previously scheduled surgery.

PART VI. BENEFITS FOR PHYSICIAN'S SERVICES

A. COVERED PHYSICIAN'S SERVICES: The following Physician's services are Covered Services under this Part VI and benefits will be provided, subject to the Exclusions and Limitations set forth in Part X, including determinations made by our Utilization Review Program.

1. Surgery: Operative invasive procedures and the treatment of fractures and dislocations provided by the Physician in charge of the case, or by a certified physician assistant within his or her scope of practice. The Maximum Benefit Amount for a surgical procedure shall include the normal preoperative and postoperative care of a Hospital Inpatient or Outpatient.

a. When multiple or bilateral surgical procedures are performed which add significant time or complexity at the same operative session, benefits will be paid at the Maximum Benefit Amount for the major procedure as determined by us. The Maximum Benefit Amount for a secondary procedure will be calculated to be 75% of the Maximum Benefit Amount which would have been allowed, had the procedure been primary. For any additional procedure, the Maximum Benefit Amount will be calculated to be 50% of the amount which would have been allowed, had the procedure been primary. We will determine the rate at which procedures should be reimbursed.

b. When a surgical procedure is performed in two or more steps or stages, payment will be limited to the amount provided for a single procedure.

2. Surgical Assistance: Payment not to exceed 20% of the Maximum Benefit Amount for surgery will be made for surgical assistance by a Physician or certified physician assistant who actively assists the operating Physician. Surgical procedures for which benefits for a surgical assistant are provided are those specifically identified by us. Such information may be obtained from us prior to surgery.

3. Anesthesia Services: The administration of an anesthetic by a Physician or a Certified Registered Nurse Anesthetist. Anesthesia services shall include the usual preoperative and postoperative visits and the administration of fluids or blood incident to the anesthesia or surgery, but shall not include administration of anesthesia by the attending or assisting surgeon (except spinal, saddle or caudal blocks) nor local infiltrations by whomsoever administered.

4. Non-Surgical Inpatient Hospital Visits: Non-Surgical Inpatient care or treatment of a condition for which surgical care is not required by the attending Physician when a Covered Person is confined as an Inpatient in a Hospital.

5. Concurrent Inpatient Hospital Visits: An Inpatient Hospital visit provided by two or more Physicians on the same day if, in our opinion, the services are:

a. For unrelated non-surgical medical diagnoses which require the services and skills of two or more Physicians with unrelated specialties; or

b. Necessary because of medical complications requiring non-surgical care not related to surgery and not a part of the usual, necessary and related preoperative and postoperative care and requiring supplemental skills not possessed by the attending surgeon or his or her assistants.

6. Inpatient Consultation Service: When a Covered Person is an Inpatient, payment will be made for one Physician consultation per specialty when the following requirements are met:

a. Requested by the attending Physician; and

b. Required by the Covered Person's Illness or Injury and beyond the special knowledge or practice specialty of the attending or other consulting Physician; and

c. Consultation includes a physical examination of the Covered Person by the consulting Physician; and

d. A written report from the consulting Physician is included in the Covered Person's Hospital chart.

7. Intensive Medical Service: Unusual, repeated and prolonged attendance at the Covered Person's bedside when required by the Illness or Injury.

8. Radiation Therapy.

9. Tissue Examinations: Tissue examinations in connection with surgical procedures, whether performed in a Hospital Inpatient or Outpatient Facility, Free-Standing Ambulatory Facility, or in the Physician's office.

10. Pap smear tests.

11. Radiology and Pathology Services: Payment will be made for such services when provided in a Hospital, Physician's office, or Free-Standing Ambulatory Facility.

12. Physician Home, Office and Outpatient Visits: Payment will be made for such Covered Services. Included within this service is care associated with renal dialysis. Such benefits will be paid until this contract terminates or until Medicare assumes responsibility for benefits.

PART VII. BENEFITS FOR COMPLICATIONS OF PREGNANCY

A. Benefits shall be paid for Medically Necessary Hospital and Physician Covered Services pursuant to Parts V and VI of this Contract under a Single Parent or Family Membership, as the result of complications of pregnancy. These are conditions whose diagnoses are distinct from pregnancy, but are caused or are adversely affected by pregnancy.

B. Benefits will be provided for all Medically Necessary radiology and pathology procedures performed in a Physician's office or the Outpatient department of a Hospital, which are related to the complications of pregnancy.

C. Benefits will not be provided pursuant to this Part VII for postpartum depression, psychosis or any other Mental Illness.

PART VIII. BENEFITS FOR ORAL SURGERY AND DENTISTRY

A. Benefits will be provided pursuant to Part IV for the following Covered Services, if performed by a Physician or Dentist:

1. The removal of impacted teeth in a provider's office, Free-Standing Ambulatory Facility or Hospital Outpatient department;

2. Incision and drainage of cellulitis;

3. Excision of exostoses, tumors and cysts, whether or not related to the temporomandibular joint of the jaw;

4. Invasive surgical procedures of the temporomandibular joint of the jaw;

5. Bone grafts to the jaw except those done to prepare the mouth for dentures;

6. Reduction of a complete dislocation or fracture of the temporomandibular joint of the jaw required as a direct result of an accidental Injury occurring while the patient was a Covered Person under this Contract.

7. Services, supplies or appliances for dental treatment of natural teeth required as the direct result of an accidental Injury occurring while this Contract is in effect. Benefits shall not be provided for such services when the Injury occurs as the result of eating, biting or chewing.

B. Benefits will be provided for Hospital Inpatient charges related to covered oral surgery and dentistry services, but only if the Hospital admission is essential to safeguard the health of the patient because of the existence of a specific non-dental physical organic impairment. Benefit payments will be made as stated in Part IV.A.2.

C. EXCLUSIONS: No payments shall be made under this part, or under any other part of this Contract, except for services expressly described in paragraph A, above, for:

1. Care in connection with the treatment, filling, removal, repositioning or replacement of teeth;

2. Root canal therapy or care;

3. Preparation of the mouth for dentures;

4. Treatment of the dental occlusion or temporomandibular joint of the jaw by any means or for any reason, except as described in Paragraphs A.4 and A.6 of this Part. No benefits will be provided for any other treatment of Temporomandibular Joint (TMJ) Syndrome;

5. All other procedures involving the teeth or structures directly related to or supporting the teeth, including:

   a. the gums;

   b. the alveolar processes; and

   c. the temporomandibular joint of the jaw.

PART IX. BENEFITS FOR OTHER COVERED SERVICES

A. OVERVIEW: Benefits will be provided for the Medically Necessary Covered Services and supplies and equipment, listed below, when ordered by a Physician, and when not covered elsewhere in this Contract.

Benefits will be provided at 80% of the Maximum Benefit Amount, where appropriate, or at 80% of billed charges.

B. COVERED SERVICES AND SUPPLIES AND EQUIPMENT:

1. Oxygen and equipment for its administration, and inhalation therapy.

2. Ambulance service to the nearest facility where the Covered Person may receive appropriate care for a Medical Emergency.

3. Up to sixty (60) Outpatient physical therapy sessions provided by a licensed Physical Therapist or other qualified person under the direct supervision of a Physician. A session is defined as a visit to the Physical Therapist not to exceed four (4) hours per day.

4. Up to sixty (60) Outpatient occupational therapy sessions consisting of range of motion exercises, strengthening exercises, and prosthetic training to achieve pain relief, restoration or function, the prevention of disability or further deterioration for the following conditions:

Hand and upper extremity injuries;

Joint dysfunction resulting from arthritis;

Post mastectomy;

Burn care;

Amputation.

Such services must be provided by a licensed occupational therapist or licensed occupational therapist assistant, under the direct supervision of a Physician. A session is defined as a visit to the Occupational Therapist not to exceed four (4) hours per day.

Benefits shall not be provided for any other occupational therapy services including, but not limited to:

Perceptual training to compensate for perceptual impairment;

Teaching and practicing the activities of daily living;

Developing prevocational capacity.

5. Speech therapy when related to a cerebral vascular accident, closed head-trauma, a cerebral tumor, external trauma, or when the patient has had a laryngectomy. Such services must be provided by a licensed speech-language pathologist or person practicing under the direct supervision of a licensed speech-language pathologist.

6. Rental or initial purchase, whichever is least costly, of Durable Medical Equipment when prescribed by a Physician. We may preauthorize a second or subsequent purchase of an item of Durable Medical Equipment, if such purchase is made necessary by a significant change in the Covered Person's condition or in the case of the growth of a child who is an Eligible Dependent. Benefits will not be provided for the repair, maintenance or adjustment of Durable Medical Equipment or for sales tax on the purchase thereof. Benefits will not be provided for Durable Medical Equipment rented, purchased from or used while confined to a Hospital, a Skilled Nursing facility, an Intermediate Care Facility, a nursing home or any other licensed residential facility if such equipment is usually supplied by such facility.

7. Any medicinal preparation which:

   a. by law requires a Physician's or Dentist's prescription or order and must bear the legend: Caution--Federal law prohibits dispensing without a prescription; and

   b. is dispensed by a registered pharmacist on the prescription or order of a Physician or Dentist; and

   c. may lawfully be dispensed by a registered pharmacist in the State of Nebraska.

8. Insulin.

9. Allergy tests and injections of allergy extracts.

10. Routine immunizations.

11. One set of eyeglasses or contact lenses or replacement of one set of eyeglasses or contact lenses, because of a change in prescription of at least one diopter as a direct result of intraocular surgery or ocular Injury, if ordered by a Physician.

12. Nursing care in the Covered Person's home, which requires the skill, proficiency and training of a registered nurse (R.N.) or a licensed practical nurse (L.P.N.), for not more than three (3) hours per day, subject to the following:

   a. the care must be ordered by a Physician;

   b. the care must not be primarily for the convenience of the patient or the patient's family;

   c. time spent bathing, feeding, transporting, exercising or moving the patient, giving oral medication or acting as a companion or sitter or homemaking, will not be considered for benefit payment under this provision.

   d. the care must not be provided by a nurse who is an immediate relative by blood, marriage or adoption, or a member of the Covered Person's household;

   e. the patient must be physically unable to be transported to receive medical care;

   f. the care must not be provided in a Hospital, a Skilled Nursing Facility, an Intermediate Care Facility, a residential care facility or a domiciliary facility.

13. Renal Dialysis: Services for renal dialysis including all charges for covered home dialysis equipment and covered disposable supplies. Benefits will also be provided for one session of dialysis training or counseling. Such benefits will be paid until this contract terminates or until Medicare assumes responsibility for benefits.

14. Cardiac Rehabilitation Program: Cardiac Rehabilitation is defined as use of various modalities of treatment to improve cardiac function as well as tissue perfusion and oxygenation through which selected patients are restored to and maintained at either a pre-illness level of activity or a new and appropriate level of adjustment.

   a. Benefit Provision:

      1) Benefits will be provided for up to six (6) weeks of Hospital Outpatient Cardiac Rehabilitation Program, for up to three (3) sessions per week.

      2) Covered Hospital Services: All services defined as Covered Services for Outpatient care by Part V of this Contract. In addition to such services, the following shall be Covered Services

when provided as part of this Cardiac Rehabilitation Program and reimbursed at the Hospital's Maximum Benefit Amount.

a) Initial cardiac rehabilitation evaluation;

b) Exercise sessions;

c) Concurrent monitoring during the exercise session for high risk patients.

3) Covered Physician Services: All Covered Physician Services as defined by Part VI which are provided to an Outpatient.

4) No coverage will be provided for:

a) Diet or dietetic instructions;

b) Smoking cessation classes;

c) Medication instruction;

d) Weight control and/or instruction;

e) Recreational therapy, educational therapy, or forms of non-medical self-care or self-help therapy;

f) Environmental control items such as air conditioners and dehumidifiers.

b. Covered Person Eligibility: Covered Persons will be eligible for the benefits provided by this paragraph 14, if they meet the following criteria:

1) Diagnoses: Services will be provided after the following:

a) An acute myocardial infarction while covered under this Contract;

b) Coronary bypass surgery;

2) The patient's condition must be such that Cardiac Rehabilitation can only be carried out safely under the direct, continuing supervision of a Physician and in a controlled hospital environment.

c. Cardiac Rehabilitation Program-Qualifications:

1) The Cardiac Rehabilitation Program must be accredited by the Joint Commission on the Accreditation of Health Care Organizations.

15. Physical Rehabilitation Program: Physical Rehabilitation is defined as the restoration of a person who was totally disabled as the result of an Illness or Injury to a level of function which allows that person to live as independently as possible. A person is totally disabled when such person has physical disabilities and needs active assistance to perform the normal activities of daily living, such as eating, dressing, personal hygiene, ambulation and changing body position.

a. Benefit Provisions: Benefits will be provided for up to sixty (60) Inpatient days for Medically Necessary Covered Services as defined by this paragraph 15. Such benefits may be precertified as set forth in paragraph f. The provider must meet the requirements of the Physical Rehabilitation Program, as defined herein.

b. Covered Hospital Services: All services defined as Covered Services for Inpatient care by Part V of this Contract. In addition to such services, the following shall be Covered Services when provided as part of this Physical Rehabilitation Program:

1) Recreational therapy;

2) Social service counseling;

3) Prosthetic devices and fitting;

4) Psychological testing.

c. Covered Physician Services: All Covered Physician Services as defined by Part VI which are provided to an Inpatient.

d. Covered Person Eligibility: Covered Person's will be eligible for the benefits provided by this paragraph 15, if they meet the following criteria:

1) The Covered Person must have intense daily involvement in two or more of the following treatment modalities:

a) Physical therapy;

b) Occupational therapy;

c) Speech therapy;

2) Inpatient rehabilitation must immediately follow the acute hospitalization for an above diagnosis.

3) Benefits for further rehabilitation will stop when: (i) further progress toward the established rehabilitation goal is minimal or unlikely; (ii) such progress can be achieved in a less intensive setting; (iii) treatment could be continued on an Outpatient basis.

e. Provider Requirements: For benefits to be available for a Physical Rehabilitation Program, the provider must be accredited by the Committee on the Accreditation of Rehabilitation Facilities (CARF).

f. Precertification Procedure: Benefits may be precertified. Precertification occurs as follows:

1) Initial Precertification: A Notice of Admission form may be completed and submitted by the Hospital or provider to us prior to or within five (5) days of the date of admission to the Program. Initial approval will be limited to a maximum of thirty (30) days. The history and physical, Physician's orders and progress notes, nurses' notes, and therapy notes are to be submitted with the Notice of Admission. If the admission is not approved by us, benefits will not be provided for those days prior to the receipt of the Notice of Admission.

2) Extension of Benefits: After the initial approval, requests for an extension of benefits must be submitted by the Hospital or provider to us every fifteen (15) days. Subsequent approvals are limited to a maximum of fifteen (15) days. The Physician's orders and progress notes, nurses' notes, therapy notes, and the request for an extension of benefits are to be submitted prior to or not later than the day through which benefits have been approved. If the extension request is not received on a timely basis and the extension is not approved by us, benefits will not be guaranteed beyond the previous approval date.

We will notify the provider by telephone and in writing about the initial approval or disapproval of coverage, as well as any subsequent approval or disapproval for an extension of benefits.

We will notify you in writing about the initial decision and any subsequent approval or disapproval. If benefits are not precertified, claims for such benefits may be denied if the Covered Person's condition or the program does not meet the criteria established by this paragraph 15 for a Physical Rehabilitation Program.

PART X. EXCLUSIONS AND LIMITATIONS

A. Benefits are not provided by this Contract for the following:

1. Services not specifically covered by this Contract, nor amounts above charges for Covered Services. Non-Covered Services include, but are not limited to, any service for, or related to:

a. Audiological examinations; audiant bone conductors; hearing aids and their fitting;

b. Blood, blood plasma or blood derivatives or fractionates, or services by or for blood donors, except administrative charges for blood furnished to a Hospital by the American Red Cross and used for a Covered Person;

c. Detection or correction by manual or mechanical means of structural imbalance, distortion, or subluxation in the human body for the purpose of removing nerve interference and its effects where it is the result of or related to distortion, misalignment or subluxation of or in the vertebral column;

d. Eye examinations, eye refractions, eyeglasses or contact lenses, eye exercises or visual training (orthoptics) except as allowed by Part IX, B, 11;

e. Hospital or Physician charges for standby availability;

f. Personal expenses while hospitalized, such as guest meals, television rental and barber services;

g. Well baby care; routine or periodic physical examinations, regardless of age;

h. Treatment and diagnostic procedures primarily for obesity or for weight reduction, regardless of diagnosis, except surgical operations;

i. Therapy which is primarily of recreational or educational nature, or forms of non-medical self-care or self-help training, and any related diagnostic testing;

j. Treatment or removal of corns, callosities, or the cutting or trimming of nails;

k. Fertility testing and related services;

l. Embryo transfer procedures; artificial insemination and invitro fertilization;

m. Interest, sales or other taxes on Covered Services, drugs, supplies or Durable Medical equipment;

n. Repairs, maintenance or adjustment of Durable Medical Equipment;

o. Charges made while the patient is temporarily out of the Hospital;

p. Music therapy, cognitive therapy and biofeedback;

q. Marital, family or similar counseling service or educational service;

r. Lodging or travel, even though prescribed by a Physician for the purpose of obtaining medical treatment, except for ambulance services as provided under Part IX;

s. Charges made for filling out claim forms or furnishing any other records or information;

t. Custodial care;

u. Cardiac Rehabilitation or Physical Rehabilitation except as provided specifically at Part IX, 14 and 15;

v. Occupational therapy, except as provided in Part V and Part IX;

w. Nutrition care or supplements;

x. Treatment for mental retardation.

If a Non-Covered Service is provided to a Covered Person, the responsibility for payment rests with the Covered Person.

2. Services not considered by us to be payable after consideration by our Utilization Review Program. Our Utilization Program consists of evaluating the use of a diagnostic, medical or surgical procedure or service, or the utilization of medical supplies, drugs or Durable Medical Equipment, compared to established criteria in order to determine benefits. The Utilization Review Program will review claims to determine the following:

a. Benefits will not be provided for services, procedures, drugs, supplies or Durable Medical Equipment, which are not Medically Necessary.

b. Benefits will not be provided for services and procedures and any drugs, supplies, or Durable Medical Equipment which are considered to be Investigative.

c. Benefits will not be provided for services and procedures and any drugs, supplies or Durable Medical Equipment which are considered to be for Cosmetic purposes unless required as a result of an Illness or Injury occurring after your effective date of coverage.

d. Benefits will not be provided for services and procedures, and any drugs, supplies or Durable Medical Equipment which are considered by us to be obsolete. Procedures will be considered to be obsolete when such procedures have been superseded by more efficacious treatment procedures, and are no longer considered effective in clinical medicine.

If we make final determination of a claim through our Utilization Review Program that a service was not payable, pursuant to the above criteria, we will not provide benefits for that service, or any related services.

3. Services provided to or for:

a. Any dependent of a Member who has a Single Membership;

b. Any person who does not qualify as an Eligible Dependent;

c. Any Covered Person before the effective date of coverage, or provided after the effective date of cancellation or termination;

d. Any Covered Person for any Pre-existing Condition or for charges incurred more than twelve (12) months from the effective date of coverage.

4. Services for Mental Illness. Mental Illness as defined in this Contract includes alcoholism, drug abuse and other controlled substance (drug) abuse.

5. Services for pregnancy or maternity except as set forth in Part VII.

6. Services for organ transplants.

7. Services for home health and hospice services.

8. Services for Illness or Injury caused directly or indirectly by war or any act of war, declared or undeclared, or sustained while performing military service.

9. Services provided in or by: (1) a Veterans Administration Hospital where the care is for a condition related to military service; or (2) any Non-Participating Hospital or other institution which is owned, operated or controlled by any government agency, except where care is provided to non-active duty Covered Persons in medical facilities.

10. Services available at government expense, whether or not such benefits are elected, except as follows:

a. Our obligation to provide benefits will be reduced by the amount of payment or benefits such person receives or would have received from Medicare. Benefits for kidney dialysis and kidney transplant services will be provided pursuant to Medicare guidelines.

b. With respect to those eligible for benefits under any other government program, except Medicaid, whether or not the person is enrolled, our obligation to provide benefits will be reduced by the amount of payments a Covered Person is eligible for under such program.

11. Services for which there is no legal obligation to pay, or for which no charge would be made if this coverage did not exist. Any charge above the charge that would have been made if no coverage existed, or any service which is normally furnished without charge shall be treated as a service for which there is no legal obligation to pay.

12. Services covered under any Workers' Compensation or Employers' Liability Law, whether or not the Covered Person asserts rights to such coverage.

13. Charges for services provided by a person who is a member of the Covered Person's immediate family by blood, marriage or adoption.

14. Services provided by a person, firm or corporation which has not obtained a certificate of need, as required by an application of the certificate of need law.

15. Charges for services by a health care provider which are not within his or her scope of practice.

16. Charges in excess of the Maximum Benefit Amount.

17. Charges made separately for services, supplies and materials when such services, supplies and materials are considered by us to be included within the charge for a total service payable under this Contract.

18. Services not specifically covered, but provided because of Hospital accreditation requirements or Hospital staff rules or regulations.

19. Services required by an employer as a condition of employment including, but not limited to, immunizations, work physicals and drug tests.

PART XI. PROCEDURES FOR FILING A CLAIM

A. Notice of Claim/Proof of Loss: A Covered Person must notify us when they have received health care services for which this Contract will pay benefits. This notice is called a claim. The claim must give us written proof of the services provided. The claim may be filed directly by you, or the Hospital, the Physician or whoever provided the service. If the service is provided by a Participating Physician, or Participating Hospital, or another Participating Provider, the claim will be filed by them. To process a claim, we must always have your Identification Number and an itemized statement from whoever provided the care describing the service and showing the amount charged. We are entitled to any additional information needed to process the claim, including the final diagnosis.

B. Time Limit for Filing a Claim: A claim should be filed within ninety (90) days of the time the services are provided, or as soon thereafter as is reasonably possible. If you do not file a claim within eighteen (18) months of the date of service, and it was reasonably possible to do so, benefits will not be paid.

IT IS SUGGESTED THAT ALL CLAIMS BE FILED WITH US AS SOON AS POSSIBLE AFTER EXPENSES ARE INCURRED.

C. Before receiving services from any provider of service, contact Blue Cross and Blue Shield of Nebraska for a Participating Provider listing.

D. Claims should be sent to:

Blue Cross and Blue Shield of Nebraska
P.O. Box 3248
Main P.O. Station
Omaha, NE 68180-0001

PART XII. SUBROGATION

A. Subrogation is our limited right to recover benefits paid for Covered Services provided as the result of injury which was willfully or negligently caused by another person. If we pay benefits for Covered Services provided to a Covered Person as the result of an injury, we are allowed to be reimbursed the amount paid for such services by the Covered Person if the Covered Person or the person who has a right to recover for a Covered Person (usually a parent or spouse), recovers the cost of such services from the person who caused the injury, or from that person's liability insurance carrier, including a "no-fault" automobile insurance carrier.

B. The Covered Person or Member agrees to assist us in any way necessary to recover such payments. The Covered Person or Member agrees not to prejudice our right to recover.

C. If the Covered Person refuses or fails to comply with this Part, we can cancel coverage, including that of any Eligible Dependents.

PART XIII. WORKERS' COMPENSATION

Benefits for services provided as the result of Illness or Injury arising out of employment for which an employer is required to furnish or pay for, pursuant to Workers' Compensation laws, are not payable under this Contract (See Part X, Exclusion Number 12). In certain instances, benefits for such services are paid in error under this Contract. If we pay for such services, we are entitled to reimbursement for such payments from the Covered Person. This reimbursement may be funded from any recovery made from the employer, or the employer's Workers' Compensation carrier.

PART XIV. STANDARD PROVISIONS

A. CERTAIN DEFENSES: All statements, in the absence of fraud, made by you shall be deemed representations and not warranties. No such statements shall void coverage or reduce the Contract benefits unless contained in the Application.

B. LEGAL ACTIONS: You cannot bring a legal action to recover under the Contract for at least sixty (60) days after written proof of loss is given to us. You cannot start a legal action after three (3) years from the date written proof of loss is required.

C. ADDRESSES FOR NOTICE: Our address is 7261 Mercy Road, Omaha, Nebraska, 68180-0001. Your address is the most recent address appearing on our records.

D. CHANGE OF OCCUPATION: No change in coverage shall be made if you or any of your Eligible Dependents change occupations except as stated in the Eligibility provision on unmarried children attending school.

E. CONFORMITY WITH STATUTES: Any Contract provision which does not conform with the laws of Nebraska or the United States is hereby amended to conform to their minimum requirements.

F. BLUE CROSS AND BLUE SHIELD OF NEBRASKA MEMBERSHIP: When this Contract becomes effective, you become a Member of Blue Cross and Blue Shield of Nebraska. You have the right to vote at the Annual Meeting of Members held at the Blue Cross and Blue Shield of Nebraska home office in Omaha. The Meeting is held at 4:00 p.m. on the second Monday of February each year. If you do not attend the Meeting, you may appoint another Member as your proxy to vote for you. To have another person vote for you, you must appoint that person in writing, and file that appointment with us at least five days before the Meeting. If you do not attend the Meeting, and do not appoint another person as your proxy, the Chairperson of the Board of Directors of Blue Cross and Blue Shield of Nebraska, or in the absence of the Chairperson, a person the Chairperson appoints, shall be your proxy to vote for you on all matters coming before the Meeting. This proxy shall be valid as long as this Contract remains in force, unless you revoke it.

PART XV. DEFINITIONS

The definitions contained in this glossary are of terms used in this Contract.

Allowable Charge: The amount billed by the provider for Covered Services, or the Maximum Benefit Amount, whichever is less.

Application: A form provided by us, executed by you, and accepted by us which becomes a part of this Contract.

Coinsurance: The amount of each Allowable Charge which the Covered Person must pay. This amount is computed as a percentage of the Allowable Charges.

Consultations: Physician's services for a patient in need of specialized care requested by the Attending Physician who does not have that knowledge.

Cosmetic Surgery: Surgery to improve the patient's physical appearance, while not materially improving the patient's essential bodily functions, regardless of emotional or psychiatric factors.

Covered Person: You or your Eligible Dependents.

Covered Services: Hospital, medical or surgical services, drugs, supplies, Durable Medical Equipment, or other health care services, for which this Contract provides benefits, provided to a Covered Person while this Contract is in effect.

Custodial Care: Care given to a patient who:

1. is mentally or physically disabled; and

2. needs a protected, monitored or controlled environment or assistance to support the basics of daily living, in an institution or at home; and

3. is not under active and specific medical, surgical or psychiatric treatment which will reduce the disability to the extent necessary to allow the patient to function outside such environment or without such assistance, within a reasonable time, which shall not exceed one year in any event.

A Custodial Care determination may still be made if the patient is under the care of a Physician; or services are being ordered to support and generally maintain the patient's condition, or provide for the patient's comfort, or assure the manageability of the patient; or the ordered services are being administered by a Registered or Licensed Practical Nurse.

Deductible Amount: An amount which the Covered Person must pay each calendar year for Covered Services before benefits are payable by this Contract.

Durable Medical Equipment: Equipment and supplies Medically Necessary to treat an Illness or Injury, to improve the functioning of a malformed body member, or to prevent further deterioration of the patient's medical condition. Durable Medical Equipment includes such items as prosthetic devices, orthopedic braces, crutches and wheelchairs.

Eligible Dependent:

1. Your spouse unless the marriage has been ended by a legal, effective decree of dissolution, divorce or separation.

2. Your unmarried children 18 years of age or less who are chiefly dependent upon you for support and maintenance;

   a. A child is "chiefly dependent upon you for support and maintenance" so long as you provide more than one-half of the child's support. Child includes stepchild, adopted child, and grandchild, who lives with you in a regular child-parent relationship, but not foster child.

   b. Reaching age 19 while a child is a Covered Person shall not end the child's coverage under this Contract as long as the child is, and remains, both:

      1) incapable of self-sustaining employment by reason of mental or physical handicap; and

      2) chiefly dependent upon you for support and maintenance.

   We must receive proof of the requirements of (1) and (2) from you within thirty-one (31) days of the child's reaching age 19 and thereafter as we require. Determination of eligibility under this provision will be made by us.

3. Your unmarried children 23 years of age or less who are chiefly dependent upon you for support and maintenance and are in full time attendance at an educational institution which has a curriculum, faculty and student body in attendance. Coverage hereunder shall continue during normal school vacation periods if the child is enrolled for the following term, subject to the terms of this contract.

4. Extension of Student Coverage for Disability. Coverage of such a student who becomes disabled after age 19 will continue hereunder if:

a. The child is incapable of attending school by reason of mental or physical handicap. This determination will be made by us.

b. Proof of such disability is furnished to us by you within thirty-one (31)) days of the disability.

c. The extended coverage shall end when your coverage under this Contract ends.

d. The extended coverage shall be subject to all the Contract provisions.

Free-Standing Ambulatory Facility: A facility for the treatment of patients, which is not connected with offices of an individual or group practice of Physicians, nor licensed as a part of a Hospital, which provides those facilities and degree of care generally found in and required of licensed Hospitals except overnight care.

Hospital: A Hospital is an institution or facility licensed by the State of Nebraska or the state in which it is located, which provides medical and surgical diagnostic and treatment services for compensation to persons with an Illness, Injury or Pregnancy, under the supervision of a staff of Physicians licensed to practice medicine and surgery and provides 24-hour per day nursing service. This definition of Hospital includes facilities licensed as general acute care hospitals, short-term hospitals, and emergency hospitals as defined by Nebraska statutes.

This definition of Hospital does not include:

1. a long-term care hospital or facility, primarily providing skilled or non-skilled nursing care, or a residential care or domiciliary care facility;

2. a rehabilitative hospital which is an Inpatient facility operated for the primary purpose of assisting in the rehabilitation of disabled persons;

3. an institution whose primary purpose is the furnishing of food, shelter, training or educational or non-medical personal services;

4. an alcoholic treatment center;

5. a drug treatment center;

6. a mental health center or a place for mental or physical rehabilitation, other than a psychiatric hospital as defined by Nebraska law.

Illness: Bodily disorder or disease.

Injury: Accidental physical harm.

Inpatient: A patient admitted to a Hospital for bed occupancy to receive necessary medical care.

Investigative Treatment: Treatment is considered investigative when the service, procedure, drug, or treatment modality has progressed to limited human application, but has not achieved recognition as being proven and effective in clinical medicine.

Such recognition may be achieved through the following:

1. Final approval for the use of a specific service, procedure, drug or treatment modality for a specific diagnosis from the appropriate governmental regulatory body;

2. Scientific evidence permitting a consensus conclusion recognizing the effectiveness of the specific service, procedure, drug or treatment modality on health outcomes for a specific diagnosis.

We shall determine whether a service, procedure, drug or treatment modality is Investigative.

Maximum Benefit Amount: A benefit amount which is the lower of the provider's billed charge for a Covered Service or the maximum amount determined by us to be reasonable. The maximum amount shall be the amount agreed upon between us and our Participating Providers for the Covered Service. If no amount has been established for a Covered Service, we may consider the charges submitted by providers for like procedures or a relative value scale which compares the complexity of services provided or any other factor we deem necessary.

Medical Emergency: The sudden and unexpected onset of symptoms or the exacerbation of a chronic condition which presents an acute, severe, and immediate life threatening situation requiring medical attention.

Medically Necessary: The services, procedures, drugs, supplies or Durable Medical Equipment provided by the Physician, Hospital or other health care provider, in the diagnosis or treatment of the Covered Person's Illness or Injury, which are:

1. Appropriate for the symptoms and diagnosis of the patient's Illness or Injury; and

2. Provided in the most appropriate setting and at the most appropriate level of services. The most appropriate setting and most appropriate level of services is that setting and that level of services which is the most cost effective without adversely affecting the Covered Person's medical condition. When this test is applied to the care of an Inpatient, the Covered Person's medical symptoms or condition must require that treatment cannot be safely provided in a less intensive medical setting; and

3. Consistent with the standards of good medical practice in the medical community of the State of Nebraska; and

4. Not provided primarily for the convenience of any of the following:

   a. the Covered Person;

   b. the Physician;

   c. the Covered Person's family;

   d. any other person or health care provider; and

5. Not considered to be unnecessarily repetitive when performed in combination with other diagnoses or treatment procedures.

We shall determine whether services provided are Medically Necessary. Services will not automatically be considered Medically Necessary because they have been ordered or provided by a Physician.

Medicare: The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendment of 1965 as amended.

Member: Any person who has been enrolled by us for Membership and is named on an Identification Card issued by us.

Mental Illness: A pathological state of mind producing clinically significant psychological or physiological symptoms (distress) together with impairment in one or more major areas of functioning (disability) wherein improvement can reasonably be anticipated with therapy. Mental Illness includes alcoholism, drug abuse and other controlled substance (drug) abuse.

Non-Participating Hospital: A Hospital which has not contracted with us to provide services.

Outpatient: A person treated in the Outpatient department or emergency room of a Hospital, or in a Free Standing Ambulatory Facility, or a Physician's office.

Participating Hospital: A Hospital which contracts with us to provide services.

Participating Physician: A licensed practitioner of the healing arts who has contracted with us to provide Covered Services.

Participating Provider: Any other licensed practitioner of the healing arts, or qualified provider of health care services, supplies, or Durable Medical Equipment who has contracted with us to provide services, supplies or Durable Medical equipment.

Physical Rehabilitation: Services provided primarily to improve the patient's ability to function in the activities of daily living, such as bathing, walking, using the toilet, eating, dressing, or homemaking.

Pre-existing Condition: Illness or Injury for which a Physician prescribed medication or rendered medical treatment or advice within 12 months prior to the effective date of coverage. A Pre-existing Condition is also defined as an Illness which exhibited symptoms within 12 months prior to the effective date of coverage or a previous Injury which exhibited symptoms or complications within 12 months prior to the effective date of coverage, either of which would lead a prudent person to seek medical treatment or advice.

Pregnancy: Includes obstetrics, abortions, threatened abortions, miscarriages, premature deliveries, ectopic pregnancies, or other conditions or complications caused by Pregnancy. A complication caused by Pregnancy is a condition that occurs prior to the end of the Pregnancy, distinct from the Pregnancy, but caused or adversely affected by it. Post-partum depression and similar diagnoses are not considered complications of Pregnancy as that terminology is used in this Contract.

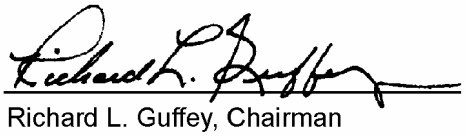
ENDORSEMENT
99-429

ENDORSEMENT

This is an Endorsement. An Endorsement is used by Blue Cross and Blue Shield of Nebraska to change your coverage. Please read it carefully. This Endorsement becomes a part of your Contract and should be attached to it.

This Endorsement changes the Benefits provision of your Blue Cross and Blue Shield of Nebraska coverage.

BLUE CROSS AND BLUE SHIELD OF NEBRASKA

By: 

Richard L. Guffey, Chairman
and Chief Executive Officer

The Contract to which this Endorsement is attached is amended as follows:

I. Part I., "Eligibility, Effective Date of Coverage," of this Contract, is amended to add the following:

Coverage shall also begin at birth for children of a Member with a Single Membership then in effect. Such coverage shall be provided for the newborn child for 31 days from the date of birth. To continue coverage for the newborn, the Member must request that his or her membership be changed to a Family or Single Parent membership within the 31-day period and pay the additional premium.

Failure to make application for coverage of the newborn, or to make payment to Blue Cross and Blue Shield of Nebraska of the premium, or both, within the time limits fixed herein, shall cause all rights and privileges to continue the Member's newborn coverage to lapse.

II. The Contract to which this Endorsement is attached is also amended in that Part II., "Charges For Coverage," Paragraph B., is deleted and a new provision added:

B. The premium is based on factors such as gender, your age, the age of a covered spouse, the number of covered children, geographic area, tobacco/non-tobacco use, as well as the Membership Unit and coverage option selected. As you or a covered spouse get older and enter into a different age classification, your premium will generally increase on the first day of the month following your birthday. Family Membership premiums will be based upon your age, the age of your spouse, and the number of children covered as Eligible Dependents.

III. The Contract is further endorsed in Part IV., "Benefits Overview":

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A. Paragraph A.3., Utilization Review, is deleted and replaced with the following:

Utilization Review: Covered Services provided by Hospital, Physicians and all other health care providers are subject to our Utilization Review Program. Utilization Review is the evaluation by us of the use of a medical, diagnostic, or surgical procedure or service or the utilization of medical supplies, drugs or Home Medical Equipment compared with established criteria in order to determine benefits. Benefits may be excluded for services, procedures, supplies, drugs or Home Medical Equipment found by us to be not Medically Necessary. Participating Providers have agreed that the Covered Person will not be responsible for the charges for services that are determined to be non-payable by our Utilization Review Program. If a claim is submitted for a Covered Service that is not Medically Necessary, the Participating Provider agrees not to charge, collect or seek collection from the Covered Person, or from us. If benefits for a service by a Non-Participating Provider are denied by Utilization Review, the Covered Person will be responsible for payment of the charge.

EXCEPTION: The Participating Provider may collect from you, however, for a specific service, procedure, drug, supply or item of medical equipment where benefits are not payable pursuant to our Utilization Review Program if, prior to the services being provided, the provider has advised you, in writing, and you have agreed in writing to be responsible for the payment. If written agreement cannot be obtained, prior verbal notification may be given by the Provider and must be documented in the patient's medical record at the time such notification is given. Use of this procedure must be limited to a specific instance and not done as a usual practice.

IV. The Contract to which this Endorsement is attached is amended at Part IV., "Benefits Overview," as follows:

PREADMISSION or ADMISSION CERTIFICATION AND CONCURRENT REVIEW: Certification authorizes payment of benefits for an Inpatient or Outpatient admission based on a review and assessment by Blue Cross and Blue Shield of Nebraska of the Medical Necessity of the admission. The appropriateness of the setting and level of care is assessed along with the timing and duration of the treatment. Certification is not a guarantee of payment, but is subject to the other terms of the Contract including, but not limited to, determination of eligibility, Pre-existing Conditions, and Part X., Exclusions and Limitations.

1. **Preadmission Certification:** Benefits for all Covered Services provided for a nonemergency Hospital Admission must be precertified. If preadmission certification is not possible, then admission certification must be obtained within 24 hours of the admission or the next business day, whichever occurs first.

2. **Admission Certification:** Notification must be given to Blue Cross and Blue Shield of Nebraska of a nonelective admission or emergency admission. Notification must be given within 24 hours of the admission, or the next day, whichever occurs first.

If Inpatient certification of benefits is denied, the Allowable Charges otherwise considered for benefit payment under this Contract for all Covered Services associated with this hospitalization will be reduced by fifty percent (50%).

If the Member does not request precertification, the Allowable Charges otherwise considered for benefit payment by this Contract for Hospital Covered Services associated with this hospitalization will be reduced by $500.00.

3. **Notification:** When certification is required, it is always the responsibility of the Covered Person (or someone acting on behalf of the Covered Person) to see that Blue Cross and Blue Shield of Nebraska is notified. (Submission of a related claim prior to hospitalization does not constitute notification.) Actual notification may be made by the Physician, a Hospital or Treatment Center, the Covered Person or someone acting on the Covered Person's behalf. Blue Cross and Blue Shield of Nebraska will notify the Physician, the Hospital, Treatment Center, the Covered Person or someone acting on the Covered Person's behalf:

a. whether or not benefits will be certified for an Inpatient Hospital or Treatment Center Admission, and

b. the number of days that will be considered Medically Necessary for such admission.

Notification to any one of the above-named constitutes notice to the Covered Person.

If the anticipated admission date changes, notification must be made.

4. **Denial of Certification:** If certification for an Inpatient admission to a Hospital or Treatment Center is denied because it is determined to be not Medically Necessary, benefits for all services which are not Medically Necessary will be denied.

5. **No Request Made:** If the Covered Person does not request precertification of benefits and is admitted to the Hospital or Treatment Center, the Allowable Charges considered for benefits under this Contract for all Covered Services associated with this admission will be reduced by $500.00. In addition, if the admission is determined to be not Medically Necessary, benefits for all services that are not Medically Necessary will be denied.

6. **Medical Emergency Admission:** The admission will be reviewed by Blue Cross and Blue Shield of Nebraska to determine if it was for a Medical Emergency and to determine if the person required Inpatient care. If the Covered Person has not requested Inpatient certification within 24 hours of the admission or the next business day, the 24-hour period prior to the time of admission and the 24-hour period after such admission will be reviewed to determine if the patient's condition and treatment would have hindered his or her ability to provide notice. (Admission through the emergency room does not necessarily constitute an emergency admission.)

If notification of an admission by the Covered Person was possible, and not made, Allowable Charges considered for benefit payment will be reduced by $500.00, and benefits for all services that are not Medically Necessary will be denied.

7. **Concurrent Review:** Concurrent Review is a review of an ongoing Inpatient or Outpatient treatment to assure that it remains the most appropriate setting for the care being provided.

If additional days beyond the number of days originally certified for benefit consideration are needed, those days also must be certified in advance. The Hospital, Treatment Center or the Physician will be contacted to determine the treatment plan. If additional days are Medically Necessary, benefits will be certified. The Physician, Hospital, Treatment Center, Covered Person, or someone acting on his or her behalf will be notified whether or not benefit payment will be certified for additional days. If the treatment is no longer Medically Necessary beyond the certified length-of-stay, benefits for services that are not Medically Necessary will be denied.

8. **Liability:** Charges for services that are determined by Blue Cross and Blue Shield of Nebraska to be not Medically Necessary will be the Covered Person's liability unless the Hospital, Treatment Center or Physician is participating with Blue Cross and Blue Shield of Nebraska. Participating Providers have agreed to hold Covered Persons harmless for services that are determined to be not Medically Necessary. The Covered Person will remain liable for any reduction of allowable charges considered for benefits as a result of failure to certify or denial of benefits.

EXCEPTION: Participating Providers may collect from the Covered Person for services that are determined by Blue Cross and Blue Shield of Nebraska to be not Medically Necessary if, prior to services being provided, they have advised that person, in writing, and the Covered Person has agreed in writing to be responsible for the payment. If written agreement cannot be obtained, verbal notification may be given by the Provider and must be documented in the patient's medical records at the time such notification is given. Use of this procedure must be limited to a specific instance and not done as a usual practice.

The benefits reductions resulting from these changes to Part IV., supersede any other benefit reduction in the Contract, including any other Endorsements to the Contract. The benefit reduction becomes an additional amount that must be paid by the Covered Person.

V. Part IV., "Benefits Overview," is further amended to delete E.1., Total Benefits, and replace it with the following:

1. The total benefits payable for each Covered Person for the treatment of all conditions is $2,000,000.

VI. Part IX., of this Contract titled: “Benefits for Other Covered Services,” is amended to delete Paragraph B., 10., and replace it with the following:

Routine immunizations. Benefits for routine immunizations are subject to any applicable Deductible Amount, except for pediatric immunizations that shall be payable without application of the Deductible Amount, as required by state or federal law. Pediatric immunizations include a complete set of vaccinations for Covered Persons from birth to six years of age for measles, mumps, rubella, poliomyelitis, diphtheria, pertussis, tetanus, and Haemophilus influenzae type B.

VII. The Contract to which this Endorsement is attached is amended to delete the part titled “Subrogation,” and replace it as follows:

SUBROGATION; CONTRACTUAL RIGHT TO RECOVERY

A. SUBROGATION: Subrogation is the right to recover benefits paid for health and dental Covered Services provided as the result of Injury or Illness that were caused by another person or organization. If benefits are paid for such Covered Services, the amount paid under this Contract for such services shall be reimbursed. The Member, Covered Person or the person who has a right to recover for a Covered Person (usually a parent or spouse), agrees to make reimbursement under this Part if payment is received for existing claims from the person who caused the Illness or Injury or from that person’s liability carrier. This recovery includes any claim by the Covered Person for special or general damages and regardless of whether or not there has been full compensation.

B. CONTRACTUAL RIGHT TO RECOVERY: By accepting coverage under this Contract, the Member agrees to grant a contractual right to collect from the proceeds recovered on his or her behalf, or on behalf of any covered dependents, for health expenses paid under this Contract, regardless of whether or not there has been full compensation. Such proceeds may include any settlement, judgment, another person’s medical payments provision of an insurance contract or proceeds otherwise paid by a third party. This contractual right of recovery is cumulative with and not exclusive of the subrogation right. Any proceeds recovered under this Part shall be primary to this Contract, and it shall not be defeated by allocating the proceeds exclusively to medical payments and/or nonmedical damages.

C. No adult Member may assign any rights to recover medical expenses from any third party to any minor or other dependent of the adult Member or to any other person, without the express written consent of Blue Cross and Blue Shield of Nebraska. The right to recover, whether by subrogation or reimbursement, shall apply to settlements or recoveries of deceased persons, minor dependents of a Member, incompetent or disabled Members or their incompetent or disabled dependents.

D. The Member agrees to assist in any way necessary to recover such payments, including but not limited to notifying Blue Cross and Blue Shield of Nebraska of a claim or lawsuit filed pursuant to this Part. He or she agrees not to interrupt or prejudice this right to recover.

E. If the Member refuses or fails to comply with this Part, coverage can be canceled, including that of any covered dependents. Costs incurred in enforcing these provisions shall also be recovered, including, but not limited to, attorneys’ fees, litigation and court costs and other expenses.

F. Subrogation does not apply to recoveries made by Covered Persons from no-fault insurance.

VIII. The Contract to which this Endorsement is attached is also amended to add at Part XIV., Standard Provisions, the following:

INDEPENDENT CORPORATION: The Member, hereby expressly acknowledges its understanding that this Contract constitutes a contract solely between such Member and Blue Cross and Blue Shield of Nebraska (Blue Cross and Blue Shield of Nebraska), which is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an Association of independent Blue Cross and Blue Shield Plans, (the “Association”) permitting Blue Cross and Blue Shield of Nebraska to use the Blue

Cross and/or Blue Shield Service Marks and that Blue Cross and Blue Shield of Nebraska is not contracting as the agent of the Association. The Member, further acknowledges and agrees that it has not entered into this Contract based upon representations by any person other than Blue Cross and Blue Shield of Nebraska and that no person, entity, or organization other than Blue Cross and Blue Shield of Nebraska shall be held accountable or liable to the Member for any of Blue Cross and Blue Shield of Nebraska's obligations created under this Contract. This paragraph shall not create any additional obligations whatsoever on the part of Blue Cross and Blue Shield of Nebraska other than those obligations created under other provisions of this Contract.