BlueCross BlueShield of Illinois

MAJOR MEDICAL EXPENSE COVERAGE
Blue Choice Preferred Bronze PPO℠ 107
Blue Choice Preferred PPO℠ Network

OUTLINE OF COVERAGE

1. READ YOUR POLICY CAREFULLY. – This outline of coverage provides a brief description of the important features of your Policy. This is not the insurance contract, and only the actual Policy provisions will control. The Policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR POLICY CAREFULLY!

2. This Coverage is designed to provide you with economic incentives for using designated health care providers. It provides, to persons insured, coverage for major Hospital, medical, and surgical expenses incurred as a result of a covered accident or sickness. Coverage is provided for daily Hospital room and board, miscellaneous Hospital services, surgical services, anesthesia services, In-Hospital medical services, and Out-of-Hospital care, subject to any Deductibles, Copayment provisions, or other limitations which may be set forth in the Policy. **Although you can go to the Hospitals and Physicians of your choice, your benefits under the Policy will be greater when you use the services of designated Hospitals and Physicians.**

3. Each benefit period you must satisfy the calendar year Deductible before your benefits will begin, except for Preventive Care Services and other Covered Services not subject to a Deductible. Expenses incurred by you for Covered Services will also be applied towards the calendar year Deductible. Refer to the Policy for more information.

Changes in some state or federal law or regulations or interpretations thereof may change the terms and conditions of coverage.

BASIC PROVISIONS	**Blue Choice Preferred Bronze PPO℠ 107**	
	YOUR COST	
Individual Deductible Per individual, per calendar year. (If you have Family Coverage, each member of your family must satisfy his/her own individual deductible.)	Participating Provider	$6,750
	Non-Participating Provider	$15,000
Family Deductible If you have Family Coverage and your family has satisfied the family Deductible amount specified, it will not be necessary for anyone else in your family to meet a calendar year Deductible in the benefit period. That is, for the remainder of that benefit period, no other family members will be required to meet the calendar year Deductible before receiving	Participating Provider	$14,300
	Non-Participating Provider	$45,000

benefits.		
Individual Out-of-Pocket Expense Limit (Not all costs count towards this limit)	Participating Provider	$7,150
	Non-Participating Provider	No limit
Family Out-of-Pocket Expense Limit (Not all costs count toward this limit)	Participating Provider	$14,300
	Non-Participating Provider	No limit
Hospitals Benefits Daily bed, board and general nursing care, and ancillary services (i.e., operating rooms, drugs, surgical dressings, and lab work).		
	YOUR COST	
Inpatient Hospital Covered Services	Participating Provider	20% of the Eligible Charge
	Non-Participating Provider	50% of the Eligible Charge
Inpatient Hospital Copayment	Participating Provider	$750 per admission
	Non-Participating Provider	$1,500 per admission
Outpatient Hospital Benefits Surgery, diagnostic services, radiation therapy, chemotherapy, electroconvulsive therapy, renal dialysis treatments and continuous ambulatory peritoneal dialysis treatment, coordinated home care program, pre-admission testing, partial hospitalization treatment program, autism spectrum disorders, habilitative services, surgical implants, maternity services, and urgent care.		
Outpatient Hospital Covered Services	Participating Provider	20% of the Eligible Charge
	Non-Participating Provider	50% of the Eligible Charge
Outpatient Surgical/Medical Covered Services from a Participating Provider	Freestanding Facility	$400 per visit, then 20% of the Eligible Charge
	Hospital	$400 per visit, then 40% of the Eligible Charge
Outpatient Surgical/Medical Covered Services from a Non-Participating Provider	50% of the Eligible Charge	
	Freestanding Facility	$80 per visit, then 20% of the Eligible Charge

Outpatient Laboratory from a Participating Provider	Hospital	$80 per visit, then 40% of the Eligible Charge
Outpatient Laboratory Services from a Non-Participating Provider	50% of the Eligible Charge	
Certain Diagnostic Tests from a Participating Provider: Computerized Tomography (CT Scan), Positron Emission Tomography (PET Scan), Magnetic Resonance Imaging (MRI)	Freestanding Facility	$700 per visit, then 20% of the Eligible Charge
	Hospital	$700 per visit, then 40% of the Eligible Charge
Certain Diagnostic Tests from a Non-Participating Provider: Computerized Tomography (CT Scan), Positron Emission Tomography (PET Scan), Magnetic Resonance Imaging (MRI)	50% of the Eligible Charge	
Outpatient Diagnostic X-Ray Services from a Participating Provider	Freestanding Facility	20% of the Eligible Charge
	Hospital	40% of the Eligible Charge
Outpatient Diagnostic X-Ray Services from a Non-Participating Provider	50% of the Eligible Charge	
Urgent Care Facility visits from a Participating Provider	$20 per visit, no Deductible	

Hospital Emergency Care	
	YOUR COST
Emergency Accident Care from either a Participating or Non-Participating Provider	20% of the Eligible Charge
Emergency Medical Care from either a Participating or Non-Participating Provider	20% of the Eligible Charge
Emergency Room Copayment (waived if admitted to the Hospital as an Inpatient immediately following emergency treatment)	$1,000 per visit
Physician Benefits Surgery, anesthesia, assistant surgeon, medical care, treatment of illness, consultations,	

mammograms, outpatient periodic health examinations, routine pediatric care, diagnostic services, injected medicines, amino acid-based elemental formulas, electroconvulsive therapy, radiation therapy, chemotherapy, cancer medications, outpatient rehabilitative therapy, autism spectrum disorders, habilitative services, rehabilitative services, outpatient respiratory therapy, chiropractic and osteopathic manipulation, hearing screening, diabetes self-management training and education, dental accident care, family planning services, outpatient contraceptive services, bone mass measurement and osteoporosis, investigational cancer treatment, infertility treatment, mastectomy related services, maternity services, and urgent care.		
	YOUR COST	
Surgical/Medical Covered Services	Participating Provider	20% of the Maximum Allowance
	Non-Participating Provider	50% of the Maximum Allowance
Outpatient office visits (Participating Providers) *(except for Outpatient periodic health examinations, routine pediatric care, pediatric routine vision examinations, Physical Therapy, Occupational Therapy, Speech Therapy, chiropractic and osteopathic manipulation, Surgery, Diagnostic Services (including, x-rays, lab services, CT, PET, MRI) and Maternity Services after the first pre-natal visit)*	No charge for first visit, then 20% of the Maximum Allowance	
Outpatient Specialist office visits (Participating Providers)	20% of the Maximum Allowance	
Mental Illness or Substance Use Disorder	Participating Provider	None
	Non-Participating Provider	50% of the Maximum Allowance
Chiropractic and Osteopathic Manipulation	25 Visit Maximum per Benefit Period	
Naprapathic Services	15 Visit Maximum per Benefit Period	
Emergency Accident Care from either a Participating or Non-Participating Provider	20% of the Maximum Allowance	
Emergency Medical Care from either a Participating or Non-Participating Provider	20% of the Maximum Allowance	
Other (Miscellaneous) Covered Services Blood and blood components; medical and surgical dressings, supplies, casts and splints, prosthetic devices, orthotic devices and durable medical equipment.	20% of Eligible Charge, Ambulance Transportation Eligible Charge or Maximum Allowance	
Certain Diagnostic Tests (CT/PET/MRI)	$700 per procedure	

Diagnostic Services (including x-rays and lab services) Deductible	$80 per procedure
Preventive Care Services from a Participating Provider Benefits will be provided for the following Covered Services and will not be subject to Coinsurance, Deductible, Copayment or dollar maximum (to be implemented in the quantity and at the time required by applicable law): Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force (USPSTF); immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and prevention with respect to the individual involved; evidenced-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA) for infants, children, and adolescents; and additional preventive care and screenings provided for in comprehensive guidelines supported by the HRSA. For purposes of this benefit, the current recommendations of the USPSTF regarding breast cancer screening and mammography and prevention will be considered the most current (other than those issued in or around November 2009).	None
Preventive Care Services from a Non-Participating Provider	50% of the Eligible Charge or Maximum Allowance
Virtual Visits Benefits will be provided for Covered Services described in the Policy for the diagnosis and treatment of non-emergency medical and behavioral health injuries or illnesses in situations when a Virtual Provider determines that such diagnosis and treatment can be conducted without an in-person primary care office visit, convenient care, urgent care, emergency room or behavioral health office visit. Benefits for Covered Services received through a Virtual Visit will only be provided if rendered by a Virtual Provider who has a specific written agreement with Blue Cross and Blue Shield to provide Virtual Visits to you at the time services are rendered.	None for first visit, then 20% of the Maximum Allowance

*The calendar year Deductible, Copayment amount, Out-of-Pocket Expense Limit and Covered Service Expense Limitation amounts may be subject to change or increase as permitted by applicable law.

PREFERRED PARTICIPATING PHARMACY OUTPATIENT PRESCRIPTION DRUG PROGRAM	
Formulary Generic Drugs and Formulary generic diabetic supplies and insulin and insulin syringes	$15 per prescription
Non-Formulary Generic Drugs and Non-Formulary generic diabetic supplies and insulin and insulin syringes	20% of the Eligible Charge per prescription
Formulary Brand Name Drugs and Formulary Brand name diabetic supplies and insulin and insulin syringes	30% of the Eligible Charge per prescription
Non-Formulary Brand Name Drugs and Non-Formulary brand name diabetic supplies and insulin and insulin syringes for which there is no Generic Drug or supply available	40% of the Eligible Charge per prescription
Non-Formulary Brand Name Drugs and Non-Formulary brand name diabetic supplies and insulin and insulin syringes for which there is a Generic Drug or supply available	40% of the Eligible Charge, plus the cost difference between the Generic and Brand Name Drugs or supplies per prescription
Specialty Drugs	50% of the Eligible Charge per prescription

PARTICIPATING PHARMACY OUTPATIENT PRESCRIPTION DRUG PROGRAM	
Formulary Generic Drugs and Formulary generic diabetic supplies and insulin and insulin syringes	$20 per prescription
Non-Formulary Generic Drugs and Non-Formulary generic diabetic supplies and insulin and insulin syringes	25% of the Eligible Charge per prescription
Formulary Brand Name Drugs and Formulary Brand name diabetic supplies and insulin and insulin syringes	40% of the Eligible Charge per prescription
Non-Formulary Brand Name Drugs and Non-Formulary brand name diabetic supplies and insulin and insulin syringes for which there is no Generic Drug or supply available	50% of the Eligible Charge per prescription
Non-Formulary Brand Name Drugs and Non-Formulary brand name diabetic supplies and insulin and insulin syringes for which there is a Generic Drug or supply available	50% of the Eligible Charge, plus the cost difference between the Generic and Brand Name Drugs or supplies per prescription
Specialty Drugs	50% of the Eligible Charge per prescription

HOME DELIVERY OUTPATIENT PRESCRIPTION DRUG PROGRAM	
Formulary Generic Drugs and Formulary generic diabetic supplies and insulin and insulin syringes	$45 per prescription
Non-Formulary Generic Drugs and Non-Formulary generic diabetic supplies and insulin and insulin syringes	20% of the Eligible Charge per prescription
Formulary Brand Name Drugs and Formulary Brand name diabetic supplies and insulin and insulin syringes	30% of the Eligible Charge per prescription
Non-Formulary Brand Name Drugs and Non-Formulary brand name diabetic supplies and insulin and insulin syringes for which there is no Generic Drug or supply available	40% of the Eligible Charge per prescription
Non-Formulary Brand Name Drugs and Non-Formulary brand name diabetic supplies and insulin and insulin syringes for which there is a Generic Drug or supply available	40% of the Eligible Charge, plus the cost difference between the Generic and Brand Name Drugs or supplies per prescription

NON-PARTICIPATING PHARMACY—OUTPATIENT PRESCRIPTION DRUG PROGRAM

When you obtain Covered Drugs, including diabetic supplies from a Non-Participating Pharmacy (other than a Participating Pharmacy), you are responsible for 50% of the amount you would have received had you obtained drugs from a Participating Pharmacy plus the Copayment Amount or Coinsurance Amount and will not apply to your calendar year deductible.

Schedule of Pediatric Vision Care Coverage

For Covered Persons Under Age 19

Pediatric Vision Care Services	**Participating covered person Cost or Discount when Covered Services are received from a Participating Vision Provider** (When a fixed-dollar Copayment is due from the covered person, the remainder is payable under the Policy up to the covered charge*)	**Non-Participating Allowance when Covered Services are received from a Non-Participating Vision Provider** (Maximum amount payable under the Policy, not to exceed the retail costs)**
Exam (with dilation as necessary, routine eye examinations do not include professional services for contact lenses)	No Copayment	Up to $30
Frames:		
"Provider-Designated" frame Frames covered under the Policy are limited to the provider-designated frames which include a selection of frame sizes (including adult sizes) for children up to age 19. The Participating Vision Provider will show you the selection of frames covered under the Policy. If you select a frame that is not included in the provider-designated frames covered under the Policy, you are responsible for the difference in cost between the Participating Vision Provider reimbursement amount for covered frames and the retail price of the frame selected. If frames are provided by aNon-Participating Vision Provider, benefits are limited to the amount shown above. Any amount 1) paid to the Non-Participating Vision Provider for the difference in cost of a non-provider-designated frame or 2) that exceeds the maximum amount payable for a Non-Participating Vision Provider supplied frame will not apply to any applicable Deductible, Coinsurance, or out-of-pocket expense limit/out-of-pocket Coinsurance maximum.	No Copayment	Up to $75
Frequency: Examination, Lenses or Contact Lenses Frame	 Once every 12-month benefit period Once every 12-month benefit period	
Standards Plastic, Glass or Polycarbonate Spectacle Lenses: Single Vision Bifocal	 No Copayment No Copayment	 Up to $25 Up to $40

Trifocal Lenticular Standard Progressive Lens	No Copayment No Copayment No Copayment	Up to $55 Up to $55 Up to $55
Lens Options (add to lens costs above): UV Treatment Standard Plastic Scratch Coating Standard Polycarbonate Photocromatic/Transitions Plastic	 No Copayment No Copayment No Copayment No Copayment	 Up to $12 Up to $12 Up to $32 Up to $57
Contact Lenses: (Contact lens allowance includes materials only)	100% coverage for provider-designated contact lenses	
Elective- Extended Wear Disposables	Up to 6 months supply of monthly or 2 week disposable, single vision spherical or toric contact lenses	Up to $150
Daily Wear/Disposable	Up to 3 months supply of daily disposable, single vision spherical contact lenses	Up to $150
Conventional	1 pair from selection of provider-designated contact lenses	Up to $150
Medically Necessary contact lenses – Preauthorization is required to be considered for benefits (see details below)		Up to $210
Contact lenses covered under the Policy are limited to the provider-designated contact		

lenses. The Participating Vision Provider will inform you of the contact lens selection covered under the Policy. If you select a lens that is not included in the pediatric lens selection covered under the Policy, you are responsible for the difference in cost between the Participating Vision Provider reimbursement amount for covered contact lenses and the retail price of the contact lenses selected. Any amount 1) paid to the Participating Vision Provider for the difference in cost of a non-provider-designated contact lens or 2) that exceeds the maximum amount payable for Non-Participating Vision Provider supplied contact lenses will not apply to any applicable Deductible, Coinsurance, or out-of-pocket expense limit/out-of-pocket limit/out-of-pocket coinsurance maximum.		

Routine eye exams do not include professional services for contact lens evaluations. Any applicable fees are the responsibility of the patient.

Value-added features:
Laser vision correction: You will receive a discount for traditional LASIK and custom LASIK from Participating Physicians and contracted laser centers. You must obtain Preauthorization for this service in order to receive coverage. Prices/discounts may vary by state and are subject to change without notice.

Additional Benefits

Medically Necessary contact lenses: Contact lenses may be determined to be medically necessary and appropriate in the treatment of patients affected by certain conditions. In general, contact lenses may be medically necessary and appropriate when the use of contact lenses, in lieu of eyeglasses, will result in significantly better visual and/or improved binocular function, including avoidance of diplopia or suppression. Contact lenses may be determined to be medically necessary in the treatment of the following conditions:

keratoconus, pathological myopia, aphakia, anisometropia, aniseikonia, aniridia, corneal disorders, post-traumatic disorders, irregular astigmatism.

Medically necessary contact lenses are covered in lieu of other eyewear. Participating providers will obtain the necessary preauthorization for these services.

Low Vision: Low vision is a significant loss of vision but not total blindness. Ophthalmologists and optometrists specializing in low vision care can evaluate and prescribe optical devices, and provide training and instruction to maximize the remaining usable vision for our members with low vision.

With prior approval from Blue Cross and Blue Shield of Illinois, covered persons who required low-vision services and optical devices are entitled to the following coverage, with both Participating and Non-Participating Providers:

Low Vision Evaluation: One comprehensive evaluation every five years (Non-Participating Allowance of $300). This examination, sometimes called a functional vision assessment, can determine distance and clarity of vision, the size of readable print, the existence of blind spots or tunnel vision, depth perception, eye-hand coordination, problems perceiving contrast and lighting requirements for optimum vision.

Low Vision Aid: Covered for one device per year such as high-power spectacles, magnifiers and telescopes (Non-Participating Allowance of $600 per device and $1200 lifetime). These devices are utilized to maximize use of

available vision, reduce problems of glare or increase contrast perception, based on the individual's vision goals and lifestyle needs. **Follow-up care:** Four visits in any five-year period (Non-Participating Allowance of $100 per visit).
Warranty: Warranty limitations may apply to Provider or retailer supplied frames and/or eyeglass lenses. Please ask your Provider for details of the warranty that is available to you.

* The "covered charge" is the rate negotiated with Participating Vision Providers for a particular Covered Service.

**** THE PLAN PAYS THE LESSER OF THE ALLOWANCE NOTED OR THE RETAIL COST. RETAIL PRICES VARY BY LOCATION.**

EXCLUSIONS AND LIMITATIONS:

Hospitalization services and supplies which are not Medically Necessary.

Services or supplies that are not specifically mentioned in the Policy.

Services or supplies for any illness or injury arising out of or in the course of employment for which benefits are available under any Workers' Compensation Law or other similar laws whether or not you make a claim for such compensation or receive such benefits. However, this exclusion shall not apply if you are a corporate officer of any domestic or foreign corporation and are employed by the corporation and elect to withdraw yourself from the operation of the Illinois Workers' Compensation Act according to the provisions of the Act.

Services or supplies that are furnished to you by the local, state or federal government and for any services or supplies to the extent payment or benefits are provided or available from the local, state or federal government (for example, Medicare) whether or not that payment or benefits are received, except however, this exclusion shall not be applicable to medical assistance benefits under Article V, VI or VII of the Illinois Public Aid Code (Ill. Rev. Stat. ch. 23 §1-1 et seq.) or similar legislation of any state, benefits provided in compliance with the Tax Equity and Fiscal Responsibility Act or as otherwise provided by law.

Services and supplies for any illness or injury occurring on or after your Coverage Date as a result of war or an act of war.

Services or supplies that do not meet accepted standards of medical and/or dental practice.

Experimental/Investigational Services and Supplies and all related services and supplies, except as may be provided under the Policy for a) Routine Patient Costs associated with Experimental/Investigational cancer treatment, if you are a qualified individual participating in a qualified clinical cancer trial, if those services or supplies would otherwise be covered under the Policy if not provided in connection with a qualified cancer trial program and b) applied behavior analysis used for the treatment of Autism Spectrum Disorder(s).

Custodial Care Service.

Long Term Care Service.

Respite Care Service, except as specifically mentioned under the Hospice Care Program section of this Policy.

Inpatient Private Duty Nursing.

Services or supplies received during an Inpatient stay when the stay is solely related to behavioral, social maladjustment, lack of discipline or other antisocial actions which are not specifically the result of Mental Illness. This does not include services or supplies provided for the treatment of an injury resulting from an act of domestic violence or a medical condition (including both physical and mental health conditions.).

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

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

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

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

Special braces, specialized equipment, appliances, or ambulatory apparatus, except as specifically mentioned in the Policy.

Blood derivatives which are not classified as drugs in the official formularies.

Eyeglasses, contact lenses or cataract lenses and the examinations for prescribing or fitting of glasses or contact lenses or for determining the refractive state of the eye which are not Medically Necessary, except as specifically mentioned in the Policy. This is exclusion is not applicable to children.

Treatment of flat foot conditions and the prescription of supportive devices for such conditions and the treatment of subluxations of the foot or routine foot care.

Routine foot care, except for persons diagnosed with diabetes.

Immunizations, unless otherwise specified in the Policy.

Maintenance Occupational Therapy, Maintenance Physical Therapy and Maintenance Speech Therapy, except as specifically mentioned in this Policy.

Acupuncture, whether for medical or anesthesia purposes.

Maintenance Care.

Hearing aids, except for bone anchored hearing aids (osseointegrated auditory implants), or examinations for the prescription or fitting of hearing aids, unless otherwise specified in the Policy. This exclusion is not applicable to children as described in the Policy.

Diagnostic Service as part of determination of the refractive errors of the eyes, auditory problems, surveys, case finding, research studies, screening, or similar procedures and studies, or tests which are Investigational, unless otherwise specified in the Policy.

Procurement or use of prosthetic devices, special appliances and surgical implants which are for cosmetic purposes, for the comfort and convenience of the patient, or unrelated to the treatment of a disease or injury.

Wigs (also referred to as cranial prostheses).

Services and supplies rendered or provided for human organ or tissue transplants other than those specifically mentioned in the Policy.

Reversals of vasectomies.

Any drugs and medicines, except as may be provided under Outpatient Prescription Drugs, that are:

- Dispensed by a Pharmacy and received by you while covered under the Policy,
- Dispensed in a Provider's office or during confinement in a Hospital or other acute care institution or facility and received by you for use on an Outpatient basis,
- Over-the-counter drugs and medicines; or drugs for which no charge is made,
- Prescription antiseptic or fluoride mouthwashes, mouth rinses or topical oral solutions or preparations,
- Retin-A or pharmacological similar topical drugs.

Abortions including related services and supplies, except when the life of the mother would be endangered if the fetus were carried to term, or when the pregnancy is the result of an act of rape or incest.

Repair and replacement for appliances and/or devices due to misuse or loss, except as specifically mentioned in the Policy.

Habilitative Services that are solely educational in nature or otherwise paid under State or Federal law for purely educational services.

Not withstanding any provision in the Policy to the contrary, any services and/or supplies provided to you outside the United States, unless you receive Emergency Accident Care or Emergency Medical Care.

GUARANTEED RENEWABILITY

Coverage under the Policy will be terminated for nonpayment of premiums. Blue Cross and Blue Shield may terminate or refuse to renew the Policy for any of the following reasons:

1. If every Policy that bears the Policy form number, is not renewed. If every Policy that bears the same Group Number, is not renewed or if Blue Cross and Blue Shield ceases to offer a particular type of coverage in the individual market. If this should occur:
   a. Blue Cross and Blue Shield will give you at least 90 days prior written notice, or such other notice, if any, permitted by applicable law or regulatory guidance.
   b. You may convert to any other individual policy Blue Cross and Blue Shield offers to the individual market.
   c. If Blue Cross and Blue Shield should terminate or refuse to terminate the Policy, it must do so uniformly without regard to any health status-related factor of covered individuals or dependents of covered individuals who may become eligible for coverage.
2. If Blue Cross and Blue Shield discontinue all health care coverage and does not renew all health insurance Policies it issues or delivers for issuance in the individual market in the state. If this should occur, Blue Cross and Blue Shield will give you at least 180 days prior written notice, or such other notice, if any, permitted by applicable law or regulatory guidance.
3. In the event of fraud or an intentional misrepresentation of material fact under the terms of the Policy. In this case, Blue Cross and Blue Shield will give you at least 30 days prior written notice, or such other notice, if any, permitted by applicable law or regulatory guidance.
4. You no longer reside, live or work in the Blue Cross and Blue Shield's network service area.
5. Failure to pay your premium in accordance with the terms of the Policy, including any timeliness requirements.
6. Other reasons described in the Policy.

Blue Cross and Blue Shield will never terminate or refuse to renew the Policy because of the condition of your health.