BlueCross BlueShield of Illinois

*Experience. Wellness. Everywhere.®*

**MAJOR MEDICAL EXPENSE COVERAGE**
**Blue PPO Silver 004**
**PPO (Participating Provider Option) 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. Participating Provider Option Coverage — 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.**

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

| BASIC PROVISIONS | Blue PPO Silver 004 | |
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| | YOUR COST | |
| **Hospital Benefits** Daily bed, board and general nursing care, ancillary services (i.e., operating rooms, drugs, surgical dressings, and lab work) | | |
| **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 the Eligible Charge or Maximum Allowance | |
| **Payment level for Surgical/Medical Covered Services** | Participating | 20% of the Maximum Allowance |
| **Payment level for Surgical/Medical Covered Services** | Non-Participating | 40% of the Maximum Allowance |
| **Physician Benefits** Surgery, anesthesia, assistant surgeon, medical care, treatment of mental 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, outpatient respiratory therapy, chiropractic and osteopathic manipulation, hearing screening, diabetes self-management training and education, routine vision examinations, dental accident care, family planning services, outpatient contraceptive services, bone mass measurement and osteoporosis, investigational cancer treatment, infertility treatment, pediatric dental services, mastectomy related services, maternity services, and urgent care. | | |

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| **Inpatient Hospital Covered Services** | Participating | 20% of the Eligible Charge |
| | Non-Participating | 40% of the Eligible Charge |
| | Non-Plan | 50% of the Eligible Charge |
| **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. | Participating | 20% of the Eligible Charge |
| | Non-Participating | 40% of the Eligible Charge |
| | Non-Plan | 50% of the Eligible Charge |
| **Outpatient office visits** *(except for Outpatient periodic health examinations, routine pediatric care, routine vision examinations, Surgery and maternity services after the first pre-natal visit)* | $35 per visit, no deductible | |
| **Outpatient Specialist office visits** | $55 per visit, no deductible | |
| **Chiropractic and Osteopathic Manipulation** | 15 Visit Maximum per Benefit Period | |
| **Naprapathic Services** | 15 Visit Maximum per Benefit Period | |
| **Individual Deductible** Per individual, per calendar year. (If you have Family Coverage, each member of your family must satisfy his/her own individual deductible.) If an insured incurs covered expenses for the Deductible in the last three months of the calendar year, that amount will be carried over as credit toward the Deductible for the following calendar year. | Participating | $3,000* |
| | Non-Participating | $6,000* |
| **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 benefits. | Participating | $9,000* |
| | Non-Participating | $18,000* |
| **Individual Out-of-Pocket Expense Limit*** | Participating | $6,350* |
| | Non-Participating | $12,700* |
| **Family Out-of-Pocket Expense Limit*** | Participating | $12,700* |
| | Non-Participating | $25,400* |

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| **Inpatient Hospital Deductible** | Participating | $250* |
| | Non-Participating | $350* |
| **Outpatient Surgical Deductible** | Participating | $200 per admission* |
| | Non-Participating | $300 per admission* |
| **Preventive Care Services** Benefits will be provided for the following Covered Services and will not be subject to Coinsurance, Deductible, Copayment or dollar maximum: 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 | |
| **Emergency Accident Care from either a Participating. Non-Participating or Non-Plan Provider Emergency Care (Accident or Illness)** | 20% of the Eligible Charge, no deductible | |
| **Emergency Medical Care from either a Participating. Non-Participating or Non-Plan Provider Emergency Care (Accident or Illness)** | 20% of the Eligible Charge, no deductible | |

| **Hospital Emergency Care** | |
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| **Emergency Accident Care from either a Participating, Non-Participating or Non-Plan Provider Emergency Care (Accident or Illness)** | 20% of the Maximum Allowance, no deductible |
| **Emergency Medical Care from either a Participating, Non-Participating or Non-Plan Provider Emergency Care (Accident or Illness)** | 20% of the Maximum Allowance, no deductible |
| **Emergency Room Copayment** *(waived if admitted to Hospital as an Inpatient immediately following emergency treatment)* | $500 per visit |
| **OUTPATIENT PRESCRIPTION DRUG PROGRAM** | |
| **Formulary Generic Drugs and Formulary generic diabetic supplies and insulin and syringes** | $0 per Prescription |
| **Non-Formulary Generic Drugs and Non-Formulary generic diabetic supplies and insulin and insulin syringes** | $10 per Prescription |
| **Formulary Brand Name Drugs and Formulary Brand name Diabetic Supplies and insulin and insulin syringes** | $50 per Prescription |
| **Non-Formulary Brand-Name Brand Drugs and Non-Formulary brand name diabetic supplies and insulin and insulin syringes for which there is no Generic Drug or supply available** | $100 per Prescription |
| **Non-Formulary Brand-Name Brand Drugs and Non-Formulary brand name diabetic supplies and insulin and insulin syringes for which there is a Generic Drug or supply available** | $100 per Prescription, plus the cost difference between the Generic and Brand Name Drugs or supplies per prescription |

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| **Specialty Drugs** | $150 per Prescription |
| **Home Delivery Prescription Drug Program** | |
| **Formulary Generic Drugs and Formulary generic diabetic supplies and insulin and syringes** | $0 per Prescription |
| **Non-Formulary Generic Drugs and Non-Formulary generic diabetic supplies and insulin and insulin syringes** | $20 per Prescription |
| **Formulary Brand Name Drugs and Formulary Brand name Diabetic Supplies and insulin and insulin syringes** | $100 per Prescription |
| **Non-Formulary Brand-Name Brand Drugs and Non-Formulary brand name diabetic supplies and insulin and insulin syringes for which there is no Generic Drug or supply available** | $200 per Prescription |
| **Non-Formulary Brand-Name Brand Drugs and Non-Formulary brand name diabetic supplies and insulin and insulin syringes for which there is a Generic Drug or supply available** | $200 per Prescription, plus the cost difference between the Generic and Brand Name Drugs or supplies per prescription |

* The program 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.

**EXCLUSIONS AND LIMITATIONS:**

Services or supplies that are not specifically mentioned in this 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.

Investigational Services and Supplies and all related services and supplies, except as may be provided under this Policy for a) the cost of routine patient care associated with 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 this 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 this Policy.

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

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 this Policy. This exclusion is not applicable to children as described in this Policy.

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

Residential Treatment Centers, except for Inpatient Substance Abuse Rehabilitation Treatment or Inpatient Mental Illness except as specifically mentioned under this Policy.

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 this 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, or

Any services and supplies provided to you incurred outside the United States if you traveled to the location for the purpose of receiving medical services

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 this Policy

Non-emergency care, services or supplies provided outside of the United States

## 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 only for 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.
   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.
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.
4. You no longer reside, live or work in the Blue Cross and Blue Shield's service area.
5. Failure to pay your premium in accordance with the terms of the Policy, including any timeliness requirements.

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