BlueCross BlueShield of Illinois

Experience. Wellness. Everywhere.®

Individual Health Insurance

Plans with a Wide Range of Options to Fit Your Budget

Apply Today!

Call us toll-free at 1-800-477-2000

Visit us on the web at bcbsil.com

Contact your authorized independent Blue Cross and Blue Shield of Illinois agent

All for You

For over 70 years, Blue Cross and Blue Shield of Illinois has been helping Illinois residents with their health care coverage needs. As the largest health insurer in Illinois, millions of people place their trust in us for our reliability, financial strength and stability.

Our individual and family health insurance plans are specifically designed to help protect you and your loved ones from today's high health care costs. Cover yourself or your family with any of our plans. Here are some of the advantages of coverage from Blue Cross and Blue Shield of Illinois:

- **Freedom to choose doctors and hospitals**
- **Choice of deductibles**
- **80% or 100% coverage for most services**
- **Prescription drug coverage, including mail order drugs**
- **100% coverage for preventive care services[1]**
- **Guaranteed renewability**
- **Coverage while traveling**
- **Health and Wellness Programs**
  - 24/7 Nurseline
    Call the Nurseline 24/7 for answers to health-related questions
  - Personal Health Manager
    A resource of online tools to help you make informed health care decisions
  - BlueExtras℠ Discount Program[2]
    Includes vision, weight management, fitness club, hearing and complementary medicine discounts
  - Care Comparison® Tool
    Compare hospitals based on performance and services available
  - Treatment Cost Advisor™
    Learn about health and health care expenses

You Get Exceptional Choice From the Largest Network of Contracting Providers

No matter which Blue Cross and Blue Shield of Illinois insurance plan you select, you'll have hundreds of providers to choose from. And with 90% of Illinois doctors and more than 200 hospitals participating in our PPO network, chances are very good that your current health care providers are included.

That's important, because you get the most value from your benefits by using network providers.

Save money by using Blue*Choice*® contracting providers!

Within this large group are providers that participate in our smaller Blue*Choice* Network. Our agreements with these hospitals, doctors and specialists allow you to save on premiums and on the cost of covered services when you are a member of a Blue*Choice* plan. You do not need to select a primary care physician, and referrals to specialists are not needed. Simply use our Provider Finder® at bcbsil.com to view a list of contracting providers that participate in our plans.

Don't Forget Dental! BlueCare® Dental PPO

You'll get dental coverage on day one—with no deductible required—for checkups, cleanings and other preventive services. You can choose any dentist you want, with no referrals needed.

Which Plan Fits You Best?

Blue Cross and Blue Shield of Illinois offers a range of health insurance plans with a wide range of deductibles and benefits for individuals and families. See the Plan Comparison Chart for a side-by-side look at plan benefits. We are confident that you will find a health insurance plan to fit your specific needs and budget.

Our family of plans includes three options: SelectBlue®, BlueValue℠, BlueEdge℠ (HSA). Each family offers numerous options designed to maximize your flexibility and choice in finding the right health insurance plan for you and your family.

SelectBlue® Family

This is our premier family of health insurance plans offering benefits, convenience and choice, similar to those provided by employer plans.

- A low copayment for doctor office visits (Copayment does not apply to visits for preventive care services.)
- Choice of 100% or 80% coverage level with a wide choice of deductibles, including $0
- Outpatient emergency care (accident or illness)
- Coverage for hospitalization, surgery and many other services
- Prescription drug coverage

BlueValue℠ Family

This family of plans lets you stretch your dollars by offering reliable health care benefits at rates designed to fit your budget.

- An affordable premium without sacrificing benefits
- Choice of 100% or 80% coverage level
- Important features like outpatient prescription drug benefits and optional maternity benefits
- Designed for those who want a high level of benefits and a lower premium

Additional Savings Opportunities

Enroll in an Advantage Plan. Share costs to lower your premium as much as 20%[4] by choosing

- $75 copayment on outpatient emergency care
- Higher out-of-pocket maximums

Enroll in a Choice Plan. Use our Blue*Choice* PPO network to lower your premium as much as 27%.[4]

BlueEdge℠ Family

BlueEdge Individual HSA[3] allows you to take charge of your health and be responsible for how you spend your health care dollars.

- Our high-deductible health insurance plans include a broad range of deductibles starting at $1,200
- Provides reliable coverage with lower premiums
- HSA-eligible individuals enjoy tax advantages
- Choice of two industry-leading provider networks:
  - ✓ Our **PPO Network** - with 90% of Illinois doctors and more than 200 participating hospitals
  - ✓ Or, our **Blue*Choice* Network** - a smaller network that lets you save on premiums when you use a contracted Blue*Choice* hospital, doctor or specialist.
  - ✓ With both of our networks, you will not need to select a primary care physician, and referrals to specialists are not needed.

Find the Plan That's Right for You

Choosing the right individual health insurance plan to fit your needs is important to you and your family. Compare our plans to find the coverage you need.

If you're looking for health insurance comparable to that offered by large employers, our SelectBlue family is for you.

The typical SelectBlue buyer is an individual or family who:

- Prefers fixed doctor visit copayments for non-preventive care services
- Regularly visits a doctor

If you're budget-conscious, the BlueValue family of plans may be for you.

The typical BlueValue buyer is a cost-conscious individual or family who:

- Is willing to assume a portion of health care costs in exchange for a lower monthly premium
- Visits doctors primarily for annual checkups

If you want to control how, when and where your health care dollars are spent, then consider a BlueEdge Individual HSA[3].

The typical BlueEdge Individual HSA buyer is an individual or family who:

- Is actively involved in their health care decisions and finances
- Seeks additional tax and retirement planning benefits
- Is willing to fund some of their own health care expenses

BlueEdge HSAs for Individuals and Families

High deductible health plans are even more attractive than ever — because they can be used with a Health Savings Account (HSA).[3] An HSA is a tax-advantaged, individually owned savings account that you can access to cover a wide range of qualified medical expenses, when funded. These expenses may generally include your annual deductible and, if applicable, any out-of-pocket cost sharing for covered services.

Here are the Major Benefits of a Health Savings Account (HSA):

Control: The money in an HSA belongs to you. YOU decide how to spend it based on your particular health care needs and budget.

Flexibility: You can withdraw your money anytime without a tax penalty as long as you use it for qualified medical expenses.

Ownership: You never forfeit your HSA balance. Any unused balance in your account rolls over from one year to the next, providing you protection from potential medical expenses.

Tax Savings[3]: An HSA allows you to put away money that may be fully tax deductible to cover future qualified medical expenses. This means that you can set aside tax-free dollars, subject to certain limits, in an HSA to pay for your qualified medical expenses. Interest that accumulates within your HSA is generally tax free. You typically will pay no taxes or penalties when you use funds from your HSA to pay for qualified medical expenses.

Step 1	Step 2	Step 3
Select and apply for one of the BlueEdge HSA plans.	Research and contact a financial institution to open a Health Savings Account (HSA) after your BlueEdge HSA health plan is activated.	Pay for your out-of-pocket qualified medical expenses out of your Health Savings Account (HSA).
• Choose the deductible and level of coverage that best fit your needs. • Choose your PPO network. • Apply online or complete and mail in your application. • Research banks offering HSAs to use in conjunction with your health plan.	• You may choose any HSA available to work in conjunction with your BlueEdge HSA health plan. Consider the associated fees, investment choices and debit card/ checkbook options to determine which HSA is right for you. • Fund your HSA as soon as possible in order to maximize your tax advantages for the year.	• Most financial institutions will give you a checkbook and/or debit card so you can pay claims directly out of your HSA. These are convenient ways to pay for prescription drugs. For doctor or hospital visits, we recommend that you ask to be billed later in case adjustments are made to your expenses. • While you are not required to open an HSA to be used with your health plan, most customers agree that they get the most out of their plan by taking advantage of the tax benefits, control and flexibility of an HSA.

Plan Comparison Chart

Participating Provider Coverage Shown[5]

	SelectBlue®		SelectBlue Advantage℠	BlueChoice℠ Select
Individual Deductible	$0, $250, $500, $1,000, $2,500 or $5,000		$250, $500, $1,000, $1,750, $2,500 or $5,000	
Coinsurance (after deductible is met)	Choice of 100% or 80%		80%	
Office Visit Copayment	$20[6]		$30[6]	$30[6]
Individual Out-of-Pocket Expense Limit	$1,000		$3,000	
Outpatient Emergency Care (physician and hospital)	100%		80% after you pay $75 copayment	
Participating Providers	PPO network, including 90% of Illinois doctors plus more than 200 participating hospitals			BlueChoice® Network[8]
Outpatient Prescription Drugs	$0, $250 and $500 Deductible:	w/$10 copayment for generics. Brand Formulary 35% Brand Non-Formulary 50%	$250 and $500 Deductible Plans: w/$10 copayment for generics. Brand Formulary 35% Brand Non-Formulary 50%	
	$1,000, $2,500 and $5,000 Deductible Plans ONLY:	80% after Deductible	$1,000, $1,750, $2,500 and $5,000 Deductible Plans ONLY: 80%	
Prescription Drug Utilization Benefit Management Programs	**Dispensing Limits**: Benefits include coverage limits on certain quantities of medicatio **Specialty Pharmacy Program**: To be eligible for maximum benefits, specialty medicat **Member Pay the Difference:** When choosing a brand name drug over an available ge **Prior Authorization/Step Therapy Requirements**: Before receiving coverage for som or cost effective drugs.			
Mental Illness Treatment and Substance Abuse Rehabilitation Treatment				
• Inpatient Hospital Care	60% first 14 days 50% thereafter		60% first 14 days 50% thereafter	
• Inpatient Physician Care	100% or 80%		80%	
• Outpatient Hospital/Physician Care	50%		50%	
Optional Maternity Coverage When elected, maternity benefits will begin 365 days after the effective date of the maternity coverage.	100% or 80%		80%	
Preventive Care	100%		100%	
Outpatient Physician Surgical Services, Hospital Services and Hospital Diagnostic Testing	100% or 80%		80%	
Inpatient Physician Medical/Surgical Services and Hospital Services and Diagnostic Testing				

BlueValue℠	BlueValue Advantage℠	BlueChoice℠ Value	BlueEdge℠ Individual HSA[3]	BlueEdge℠ Individual HSA 5000[3]
$250, $500, $1,000, $2,500 or $5,000	$250, $500, $1,000, $1,750, $2,500 or $5,000		$1,200, $1,750, $2,600 or $3,500	$5,000
Choice of 100% or 80%	80%		Choice of 100% or 80%	100%
None—subject to deductible and coinsurance	None—subject to deductible and coinsurance	None—subject to deductible and coinsurance	Subject to deductible	Subject to deductible
$1,000	$3,000		Annual deductible plus $3,000[7]	Annual deductible
100%	80% after you pay $75 copayment		100% or 80%	100%
PPO network, including 90% of Illinois doctors plus more than 200 participating hospitals		BlueChoice® Network[8]	PPO network, including 90% of Illinois doctors plus more than 200 participating hospitals, or BlueChoice® Network[8]	
80% After deductible			100% or 80% After deductible	100% After deductible

ns.

tions must be obtained through the preferred Specialty Pharmacy Provider.

neric equivalent, you pay your usual share plus the difference in cost.

e medications, your doctor will need to receive authorization from BCBSIL and you may first need to try more clinically appropriate

60% first 14 days 50% thereafter 100% or 80% 50%	60% first 14 days 50% thereafter 80% 50%	60% first 14 days 50% thereafter 100% or 80% 50%	100%
100% or 80%	80%	100% or 80%	100%
100%	100%	100%	100%
100% or 80%	80%	100% or 80%	100%

BlueCare Dental PPO for Individuals and Families

Now is the time to add Dental Coverage

Choose BlueCare Dental PPO and Enjoy:

- No deductible required for checkups, cleanings and other preventive services
- A maximum annual benefit of up to $1,500 per person per year
- Up to a 20% discount for orthodontic services at participating dentists

BlueCare Dental PPO Eligibility:

- You must enroll in a Blue Cross and Blue Shield of Illinois health plan to be eligible to enroll in the dental plan. This is your only opportunity to add dental coverage to your medical policy—with no medical questions asked
- All members on that health plan must be enrolled in BlueCare Dental PPO
- Once your dental plan is dropped for any reason, you cannot reenroll unless you reenroll in a BCBSIL health plan

Benefits[9]	Participating Dentists	Non-Participating Dentists[10]
Deductible Deductible applies to Type III services only	$50 per member per benefit period; $150 maximum per family	
Calendar Year Maximum Benefit (per individual)	$1,500[10]	
Type I Services • Cleanings • Sealants • Examinations • Space maintainers • X-rays	100% of Maximum Allowance	50% of Maximum Allowance
Type II Services • Fillings • Simple extractions	80% of Maximum Allowance	50% of Maximum Allowance
Type III Services • Bridges[11] • Endodontics • Crowns[11] • Oral Surgery • Dentures[11] • Periodontics	50% of Maximum Allowance after deductible	50% of Maximum Allowance after deductible
Orthodontics Not an insured benefit. Up to a 20% discount, up to a maximum savings of $1,000, is available to you for services received from a participating dentist.	Up to a 20% discount, up to a maximum savings of $1,000	Not available

Illinois ZIP Codes 600 – 608 Region 1	
Member	$30.55
Member + Spouse	$61.05
Member + Child(ren)	$52.35
Family	$89.55
Illinois ZIP Codes 609 – 629 Region 2	
Member	$28.80
Member + Spouse	$57.60
Member + Child(ren)	$49.40
Family	$84.45

See Why **More Than 7 Million People**

Choose Blue Cross and Blue Shield of Illinois

Our Contracting Provider Networks Assure You Freedom of Choice

Blue Cross and Blue Shield of Illinois health insurance plans provide access to the largest PPO network in Illinois, which includes 90% of Illinois doctors and more than 200 participating hospitals. In fact, with our extensive PPO Network, it's likely that your current health care providers participate.

Our Blue*Choice* Select and Blue*Choice* Value health insurance plans give you access to our smaller Blue*Choice* Network. Our agreements with these hospitals, doctors and specialists allow you to save on premiums and the costs of covered services when you are a member of a Blue*Choice* plan.

Remember, with our BlueEdge℠ Individual HSA plans, now you can choose either our PPO Network or our Blue*Choice* Network.

Blue Cross and Blue Shield of Illinois Offers You and Eligible Family Members Choices

Blue Cross and Blue Shield of Illinois offers you and eligible family members choices when it comes to your care. Members and eligible dependents have the freedom to visit any physician they choose, with benefits paid at the highest level when the doctor is in the participating provider network. Members do not need to select a primary care physician to coordinate care, and no referrals are needed to see a specialist.

Travel with Confidence — You're Covered Away from Home

As a member of Blue Cross and Blue Shield of Illinois, you'll have access to a program called BlueCard® PPO. Contracting providers outside Illinois linked through the BlueCard program allow you to receive benefits for covered services when you travel. Simply present your Blue Cross and Blue Shield of Illinois ID card to a participating provider wherever you are. To find a participating provider while you're away, just call the toll-free number on the back of your card. It's that easy.

No Paperwork in Most Cases — Your Claims Are Handled for You

Present your Blue Cross and Blue Shield of Illinois ID card to your health provider. They will submit a claim, and Blue Cross and Blue Shield of Illinois will send you an Explanation of Benefits, which will also show you how much of your deductible and your out-of-pocket maximum you have met to date as well as your applicable share of costs.

Notes

1 Applies to services provided in-network only.

2 The relationship between these vendors and Blue Cross and Blue Shield of Illinois (BCBSIL) is that of independent contractors. BlueExtras is a discount program available to BCBSIL members. Some of the services offered through BlueExtras may be covered under your health plan. Please refer to your benefit booklet or call the customer service number on the back of your ID card for specific benefit information under your health plan. Use of BlueExtras does not affect your premium, nor do costs of BlueExtras' services or products count toward your calendar year and/or plan deductibles. Discounts are only available through participating vendors. BCBSIL does not guarantee or make any claims or recommendations regarding the services or products offered under BlueExtras. You may want to consult with your physician prior to use of these services and products. BCBSIL reserves the right to discontinue or change this discount program at any time without notice.

3 Please be reminded that Health Savings Accounts (HSA) have tax and legal ramifications. Blue Cross and Blue Shield of Illinois does not provide legal or tax advice, and nothing herein should be construed as legal or tax advice. These materials, and any tax-related statements in them, are not intended or written to be used, and cannot be used or relied on, for the purpose of avoiding tax penalties. Tax-related statements, if any, may have been written in connection with the promotion or marketing of the transaction(s) or matter(s) addressed by these materials. You should seek advice based on your particular circumstances from an independent tax advisor regarding the tax consequences of specific health insurance plans or products.

4 Savings based on a 24-year old male nonsmoker in metro Chicago. All policies are underwritten on an individual basis, and your rate may vary.

5 Benefits reduced when non-participating providers are used. This is a summary of highlights only. Please refer to the Outline of Coverage for each plan for additional details.

6 Not subject to Deductible. Does not apply to out-of-pocket expense limit.

7 The individual out-of-pocket expense plus individual deductible cannot exceed $5,000.

8 Blue*Choice* provides you with access to contracting providers.

9 Your dental care benefits are highlighted in this chart. To fully understand all the terms, conditions, limitations and exclusions which apply to your benefits, please read the entire BlueCare Dental PPO Rider.

10 For services received from a non-participating dentist, the member will be responsible for any difference between the dentist's charges and the maximum allowable charge. The maximum allowable charge is based on our network negotiated fees. Further information regarding the maximum allowable charge and network status of dentists is available by calling the toll-free telephone number on the back of your identification card.

11 Benefit Waiting Period – You must be continuously covered under your rider for twelve (12) months before being eligible for the following covered services: (1) Major Restorative Services; (2) Prosthodontic Services; and (3) Miscellaneous Restorative and Prosthodontic Services.

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Questions?

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Visit us on the web at bcbsil.com

Contact your authorized independent Blue Cross and Blue Shield of Illinois agent

31741.0112

Blue Cross and Blue Shield of Illinois (BCBSIL) Individual Coverage Plan Selection

BlueCross BlueShield of Illinois

HOME OFFICE USE ONLY

To help us process your application promptly, please remember:

- **You must complete and submit the Illinois Standard Health Application for Individual and Family Coverage in addition to this Individual Coverage Plan Selection form to apply for a BCBSIL insurance plan.**
- Please print clearly in **blue or black ink**. Pencil will not be accepted.
- In addition to having a permanent residence in Illinois, all persons applying for coverage who are not U.S. citizens must have resided in the U.S. for at least six months ***AND*** have had a complete physical by a physician in the U.S. within the past two years.
- BCBSIL individual insurance plans do not cover domestic partners.
- To help us process your application promptly, please include your first month's premium if paying by check.

SECTION A — PRIMARY APPLICANT INFORMATION (please print)

First Name	Middle Initial	Last Name	Date of Birth	Gender ☐ M ☐ F

Residential Street Address *(no P.O. Boxes)*	City / State / ZIP

County	Primary Phone # ☐ Home ☐ Cell ☐ Business ( )

E-mail

CHECK ONE of the following boxes: ☐ New Business ☐ Plan Upgrade ☐ Add Spouse or Child(ren)

SECTION B — PLAN SELECTION: (please choose only one health plan with one deductible and one level of coverage)

☐ **SelectBlue®**
Deductible: ☐ $0 ☐ $250 ☐ $500 ☐ $1,000 ☐ $2,500 ☐ $5,000
Level of Coverage: ☐ 100% ☐ 80%

☐ **SelectBlue Advantage℠**
Deductible: ☐ $250 ☐ $500 ☐ $1,000 ☐ $1,750 ☐ $2,500 ☐ $5,000
Level of Coverage: ☐ 80%

☐ **BlueChoice℠ Select**
Deductible: ☐ $250 ☐ $500 ☐ $1,000 ☐ $1,750 ☐ $2,500 ☐ $5,000
Level of Coverage: ☐ 80%

☐ **BlueValue℠**
Deductible: ☐ $250 ☐ $500 ☐ $1,000 ☐ $2,500 ☐ $5,000
Level of Coverage: ☐ 100% ☐ 80%

☐ **BlueValue Advantage℠**
Deductible: ☐ $250 ☐ $500 ☐ $1,000 ☐ $1,750 ☐ $2,500 ☐ $5,000
Level of Coverage: ☐ 80%

☐ **BlueChoice℠ Value**
Deductible: ☐ $250 ☐ $500 ☐ $1,000 ☐ $1,750 ☐ $2,500 ☐ $5,000
Level of Coverage: ☐ 80%

☐ **BlueEdge℠ Individual HSA**
Deductible:
☐ $1,200 for a single applicant or $2,400 for a family*
☐ $1,750 for a single applicant or $3,500 for a family
☐ $2,600 for a single applicant or $5,200 for a family
☐ $3,500 for a single applicant or $7,000 for a family
Level of Coverage: ☐ 100% ☐ 80%
Network Selection: ☐ PPO Network ☐ BlueChoice℠ Network
** The deductible amount will be adjusted automatically if the amount is lower than the amount required by law.*

☐ **BlueEdge℠ Individual HSA 5000**
Deductible: $5,000 for a single applicant or $10,000 for a family
Level of Coverage: ☐ 100%
Network Selection: ☐ PPO Network ☐ BlueChoice℠ Network

OPTIONAL COVERAGE:

☐ **Include Maternity Coverage?**
You MUST choose a health plan in order to apply for maternity coverage.

☐ **BlueCare® Dental PPO**
You MUST choose a health plan in order to apply for dental.

SECTION C — CURRENT OR PREVIOUS BCBS COVERAGE

Does any person applying for coverage currently have, or did they previously have **within the last 5 years**, Blue Cross and Blue Shield coverage, either as a primary insured, spouse or as a dependent? ☐ **Yes** ☐ **No** ***If "yes", please complete the following:***

Applicant Name _____ Name on Previous Policy *(if applicable)* _____ Member/Group# *(optional)* _____ State _____

Applicant Name: _____ Name on Previous Policy *(if applicable)* _____ Member/Group# *(optional)* _____ State _____

SECTION D — BILLING INFORMATION

Note: Do not cancel any current coverage you may have until your new policy is approved and in force.
PREMIUM AMOUNT ENCLOSED: $_____ Make check payable to Blue Cross and Blue Shield of Illinois. Processing will be delayed or applicant will be withdrawn if appropriate premium is not received with your application.

PAYMENT OPTION (Select One): ☐ **A**. Monthly Bank Draft ☐ **B**. Two-Month Direct Bill

☐ **C**. List Bill (submit a "Personal Health Insurance Certificate for Employees" form with the application) *See Name of Employer box below.*

Please DEDUCT the following from my checking or savings account:

☐ Initial Premium ☐ Ongoing Monthly Premium ☐ Both Initial & Ongoing Premiums

Option A Information Required: Name of Bank, City and State where account is authorized _____

Please check one: ☐ Checking Account ☐ Savings Account

Bank Transit Number:_____

Depositor's Account Number: _____

Depositor's Signature:_____ Date _____

Options B & C Information Required: Billing Name and Address (If different than applicant name and residential address. If an address is entered in this section, only the billing will be sent to this address; all other correspondence will be sent to the address in Section A, unless you request otherwise.) Name of Employer is required if Option C is chosen.

First Name, Middle Initial, Last Name	
Billing Street Address *(P.O. Boxes acceptable)*	City / State / ZIP
Name of Employer *(if requesting Payment Option C. List Bill only)*	

SECTION E — PROXY INFORMATION

PROXY The undersigned hereby appoints the Board of Directors of Health Care Service Corporation, a Mutual Legal Reserve Company, or any successor thereof ("HCSC"), with full power of substitution, and such persons as the Board of Directors may designate by resolution, as the undersigned's proxy to act on behalf of the undersigned at all meetings of members of HCSC (and at all meetings of members of any successor of HCSC) and any adjournments thereof, with full power to vote on behalf of the undersigned on all matters that may come before any such meeting and any adjournment thereof. The annual meeting of members shall be held each year in the corporate headquarters on the last Tuesday of October at 12:30 p.m. Special meetings of members may be called pursuant to notice mailed to the member not less than 30 nor more than 60 days prior to such meetings. This proxy shall remain in effect until revoked in writing by the undersigned at least 20 days prior to any meeting of members, or by attending and voting in person at any annual or special meeting of members.

Primary Applicant Signature *(optional)*: X _____

Print Your Name as You Signed It: _____ **Date Signed:** _____ / _____/ _____
Mo./Day/Yr.

SECTION F — REQUIRED SIGNATURES (AGENT, IF APPLICABLE)

I certify that I have received the required Outline of Coverage.

Primary Applicant Signature: X _____ **Date Signed:** _____ / _____/ _____
Mo./Day/Yr.

Agent Signature: X _____ **Date Signed:** _____ / _____/ _____
Mo./Day/Yr.

Print Agent Name: _____ **Agent Code:** _____

Agent Phone Number: ( ) _____ **Agent Fax Number:** ( ) _____

Agent Email Address:_____

Mail Policy(ies) to: ☐ **Agent** ☐ **Applicant**

We must also receive your application within 60 days of the earliest date signed, so please return promptly. Applications received after 60 days will require a new application.

Coverage for preexisting medical conditions may be excluded or be subject to a waiting period of up to 24 months including for dependents under age 19 being added to a policy that was in effect prior to 3/23/10.

QUESTIONS?

1. Call our Customer Service Department toll-free at **1-800-654-7385**
2. Call your insurance agent
3. Visit **bcbsil.com**

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

Illinois Standard Health Application for Individual & Family Health Insurance Coverage

For assistance in completing this application, please contact your insurance agent or the insurance company directly. For information about your health insurance rights under state and federal law, and other resources, please contact the Illinois Department of Insurance's Office of Consumer Health Insurance toll free at (877) 527-9431.

INSTRUCTIONS:

1. Any information you provide in this application is confidential.
2. The answers you provide in this application must be true and complete, to the best of your knowledge and belief. Do not leave any question unmarked.
3. An intentional misrepresentation may result in your policy being modified or terminated, or in claims being reduced or denied.
4. For purposes of this application, the term "dependent" refers to any child up to age 26 (or age 30 for military veterans) for whom you are requesting coverage, regardless of whether the child may be considered a dependent for tax or other purposes. For information about Illinois' Young Adult Dependent Coverage law, which allows parents to cover children up to age 26, and up to age 30 for military veterans, please visit the Illinois Department of Insurance website at www.insurance.illinois.gov.

A Primary Applicant Information

Name (Last)	(First)	(MI)
Residential Street Address:		Apt #:
City:	State:	Zip:
Mailing Address (if different):		Apt #:
City:	State:	Zip:
Primary Phone Number: ( )	Best time to call: ☐ Morning ☐ Afternoon ☐ Evening	
Secondary Phone Number: ( )	Best time to call: ☐ Morning ☐ Afternoon ☐ Evening	
Email Address (optional):		

Please check one of the following boxes: ☐ New Application ☐ Dependent Addition ☐ Plan Change ☐ Reinstatement

Requested Effective Date: _____ (Coverage not in force until the insurance carrier approves your application and determines the effective date.)

B Employment Information

Occupation:	Job Title:
Spouse/Domestic Partner's Occupation:	Job Title:

Currently employed? (optional) Self: ☐ Yes ☐ No Spouse/Domestic Partner: ☐ Yes ☐ No

PRIMARY APPLICANT NAME ______________________________________ DATE _________________________

C Persons Requesting Coverage

List all family members you wish to include under the policy. Insurance companies may have different rules about who may qualify as an eligible dependent. For more information regarding the available coverage, please check with your insurance agent or insurance carrier.

Note: For purposes of this application, an "eligible military veteran" is a veteran who served in the active or reserve components of the U.S. Armed Forces, including the National Guard, and who received a release or discharge other than a dishonorable discharge.

If additional space is required, please attach a separate sheet and be sure to sign and date that sheet.

Self Name (Last) (First) (MI)	
Social Security Number (for internal use only):	Date of Birth: / /
State of Birth (country if born outside the U.S.):	Gender: ☐ Male ☐ Female
Percentage of time annually spent outside of Illinois for residence, work, or school:	
Spouse/Domestic Partner Name (Last) (First) (MI)	
Social Security Number (for internal use only):	Date of Birth: / /
State of Birth (country if born outside the U.S.):	Gender: ☐ Male ☐ Female
Percentage of time annually spent outside of Illinois for residence, work, or school:	
Dependent Name (Last) (First) (MI)	
Relationship to Applicant:	Date of Birth: / /
Social Security Number (for internal use only):	Gender: ☐ Male ☐ Female
Eligible Military Veteran: ☐ Yes ☐ No	
Percentage of time annually spent outside of Illinois for residence, work, or school:	
Dependent Name (Last) (First) (MI)	
Relationship to Applicant:	Date of Birth: / /
Social Security Number (for internal use only):	Gender: ☐ Male ☐ Female
Eligible Military Veteran: ☐ Yes ☐ No	
Percentage of time annually spent outside of Illinois for residence, work, or school:	
Dependent Name (Last) (First) (MI)	
Relationship to Applicant:	Date of Birth: / /
Social Security Number (for internal use only):	Gender: ☐ Male ☐ Female
Eligible Military Veteran: ☐ Yes ☐ No	
Percentage of time annually spent outside of Illinois for residence, work, or school:	

PRIMARY APPLICANT NAME _____ DATE _____

Dependent Name (Last) (First) (MI)

Relationship to Applicant: Date of Birth: / /

Social Security Number (for internal use only): Gender: ☐ Male ☐ Female

Eligible Military Veteran: ☐ Yes ☐ No

Percentage of time annually spent outside of Illinois for residence, work, or school:

D Current/Prior Coverage Information

For EACH person listed on this application, please indicate any public health insurance coverage (for example, Medicare, HFS Medical Card, All Kids, Family Care, or other federal and state programs) or private health insurance in effect within the **last 12 months**. Each person applying for insurance must be listed below. If health insurance coverage was not in effect within the **last 12 months**, please indicate **NONE.**

Self Name (Last) (First) (MI)

▶ **Current/Most Recent Coverage**:
☐ None ☐ Medicare ☐ Other Public ☐ Private (Insurer: _____)

▶ **Dates of Coverage**: From: _____/_____/_____ To: _____/_____/_____

▶ Is the issuance of this coverage **replacing** your existing coverage?* ☐ Yes ☐ No

▶ **Prior Coverage (if any):**
☐ None ☐ Medicare ☐ Other Public ☐ Private (Insurer: _____)

▶ **Dates of Coverage**: From: _____/_____/_____ To: _____/_____/_____

Spouse/Domestic Partner Name (Last) (First) (MI)

▶ **Current/Most Recent Coverage**:
☐ None ☐ Medicare ☐ Other Public ☐ Private (Insurer: _____)

▶ **Dates of Coverage**: From: _____/_____/_____ To: _____/_____/_____

▶ Is the issuance of this coverage **replacing** your existing coverage?* ☐ Yes ☐ No

▶ **Prior Coverage (if any):**
☐ None ☐ Medicare ☐ Other Public ☐ Private (Insurer: _____)

▶ **Dates of Coverage**: From: _____/_____/_____ To: _____/_____/_____

Dependent Name (Last) (First) (MI)

▶ **Current/Most Recent Coverage**:
☐ None ☐ Medicare ☐ Other Public ☐ Private (Insurer: _____)

▶ **Dates of Coverage**: From: _____/_____/_____ To: _____/_____/_____

▶ Is the issuance of this coverage **replacing** your existing coverage?* ☐ Yes ☐ No

▶ **Prior Coverage (if any):**
☐ None ☐ Medicare ☐ Other Public ☐ Private (Insurer: _____)

▶ **Dates of Coverage**: From: _____/_____/_____ To: _____/_____/_____

ILLINOIS STANDARD HEALTH APPLICATION FOR INDIVIDUAL & FAMILY HEALTH INSURANCE COVERAGE

PRIMARY APPLICANT NAME ____________________________________ DATE ________________________

Dependent Name (Last) ____________________ (First) ____________________ (MI) ____

▶ **Current/Most Recent Coverage**:
☐ None ☐ Medicare ☐ Other Public ☐ Private (Insurer: ____)
▶ **Dates of Coverage**: From: ________/________/________ To: ________/________/________
▶ Is the issuance of this coverage **replacing** your existing coverage?* ☐ Yes ☐ No

▶ **Prior Coverage (if any):**
☐ None ☐ Medicare ☐ Other Public ☐ Private (Insurer: ____)
▶ **Dates of Coverage**: From: ________/________/________ To: ________/________/________

Dependent Name (Last) ____________________ (First) ____________________ (MI) ____

▶ **Current/Most Recent Coverage**:
☐ None ☐ Medicare ☐ Other Public ☐ Private (Insurer: ____)
▶ **Dates of Coverage**: From: ________/________/________ To: ________/________/________
▶ Is the issuance of this coverage **replacing** your existing coverage?* ☐ Yes ☐ No

▶ **Prior Coverage (if any):**
☐ None ☐ Medicare ☐ Other Public ☐ Private (Insurer: ____)
▶ **Dates of Coverage**: From: ________/________/________ To: ________/________/________

Dependent Name (Last) ____________________ (First) ____________________ (MI) ____

▶ **Current/Most Recent Coverage**:
☐ None ☐ Medicare ☐ Other Public ☐ Private (Insurer: ____)
▶ **Dates of Coverage**: From: ________/________/________ To: ________/________/________
▶ Is the issuance of this coverage **replacing** your existing coverage?* ☐ Yes ☐ No

▶ **Prior Coverage (if any):**
☐ None ☐ Medicare ☐ Other Public ☐ Private (Insurer: ____)
▶ **Dates of Coverage**: From: ________/________/________ To: ________/________/________

* If answering **"YES"** please carefully read the following notice.

NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT & HEALTH INSURANCE

According to information you have furnished, you intend to lapse or otherwise terminate existing accident and health insurance and replace it with a policy to be issued by the insurance carrier. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

1. Health conditions which you may presently have (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.
2. You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interests to make sure you understand all the relevant factors involved in replacing your present coverage.
3. If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical/health history. Failure to include all material medical information on an application may provide a basis for the insurance carrier to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, re-read it carefully to be certain that all information has been properly recorded.
4. It is recommended that you do not terminate your present contract until you are certain that your application for the new contract has been approved by the insurance carrier.

PRIMARY APPLICANT NAME _____ DATE _____

DEPENDENT NAME (If submitted separately) _____

E Health Statement

The federal **Genetic Information Nondiscrimination Act** prohibits health insurers from asking for and using **"genetic information"** when deciding whether to offer coverage and how much to charge for coverage. For more information on the Genetic Information Nondiscrimination Act, please visit the Illinois Department of Insurance website at www.insurance.illinois.gov.

Instructions:

1. Each medical question below applies to each person requesting coverage.
2. Answer the questions below by checking Yes or No. If you answer Yes to any question, you must provide additional information in Section F below.
3. Do not leave any question unmarked.

Limited Privacy Available: Persons age 18 or older may submit a signed and dated separate health statement. The information provided in such separate health statement(s) will likely be disclosed to the primary applicant.

1 For any of the following conditions, **within the past FIVE (5) years**, has anyone applying for coverage:

- Been diagnosed with;
- Had treatment or testing recommended;
- Received treatment, including prescription medications; or
- Been hospitalized for any illness, injury, or health condition listed below?

If answering "YES," check all that apply.

A. **Heart/Circulatory Conditions/Disorders:** ☐ **Yes** ☐ **No**

▶ **Heart:** ☐ Heart attack ☐ Chest pain ☐ Heart murmur ☐ Irregular heartbeat
☐ High/elevated blood pressure* ☐ High/elevated cholesterol*

* If applicable, please provide last known blood pressure or cholesterol reading in Section F.

▶ **Circulatory:** ☐ Anemia ☐ Bleeding/clotting disorder ☐ Varicose/spider veins ☐ Phlebitis

B. **Lymphatic Conditions/Disorders:** ☐ **Yes** ☐ **No**

☐ Lymphadenopathy ☐ Enlarged lymph nodes ☐ Disease of the spleen

C. **Cancer/Tumors/Growths:** ☐ **Yes** ☐ **No**

☐ Cancer ☐ Tumors ☐ Cysts ☐ Polyps ☐ Lumps ☐ Other abnormal growths

D. **Respiratory Conditions/Disorders:** ☐ **Yes** ☐ **No**

☐ Asthma ☐ Bronchitis ☐ Emphysema ☐ Sleep apnea ☐ Pneumonia ☐ Tuberculosis
☐ Chronic obstructive pulmonary disease (COPD)

E. **Intestinal/Digestive Conditions/Disorders:** ☐ **Yes** ☐ **No**

☐ Acid reflux ☐ Ulcers ☐ Hernia *(indicate type)* ☐ Colitis ☐ Hemorrhoids ☐ Rectal bleeding ☐ Gallstones
☐ Irritable bowel syndrome ☐ Chronic diarrhea ☐ Hepatitis *(indicate type)* ☐ Elevated liver function test
☐ Jaundice ☐ Cirrhosis ☐ Gallbladder infection or inflammation ☐ Pancreatitis ☐ Crohn's disease

F. **Urinary Conditions/Disorders:** ☐ **Yes** ☐ **No**

☐ Kidney infection ☐ Kidney stones ☐ Bladder infection ☐ Cystitis ☐ Urinary reflux
☐ Urinary tract infection

G. **Metabolic/Endocrine Conditions/Disorders:** ☐ **Yes** ☐ **No**

☐ Diabetes ☐ Thyroid disorder ☐ High/low blood sugar ☐ Adrenal, pituitary, or other glandular disorder
☐ Chronic fatigue syndrome ☐ Obesity/weight loss surgery

PRIMARY APPLICANT NAME _____ DATE _____

DEPENDENT NAME (If submitted separately) _____

H. **Brain/Nervous System Conditions/Disorders:** ☐ **Yes** ☐ **No**

☐ Seizures ☐ Migraine headaches/Chronic severe headaches ☐ Head injury ☐ Paralysis ☐ Epilepsy
☐ Tremor ☐ Stroke or TIA ☐ Multiple sclerosis ☐ Parkinson's ☐ Restless leg syndrome
☐ Lou Gehrig's disease (ALS)

I. **Immune System Conditions/Disorders:** ☐ **Yes** ☐ **No**

☐ HIV positive ☐ AIDS ☐ Diseases associated with AIDS

J. **Musculoskeletal Conditions/Disorders:** ☐ **Yes** ☐ **No**

☐ Arthritis ☐ Gout ☐ Lupus ☐ Herniated disc ☐ Temporomandibular joint disorder (TMJ)
☐ Carpal tunnel syndrome ☐ Disease/disorder of the back or spine ☐ Other bone or joint disorder

K. **Mental/Behavioral/Emotional Conditions/Disorders:** ☐ **Yes** ☐ **No**

☐ Depression ☐ Anxiety disorder ☐ Attention deficit disorder ☐ Chemical imbalance ☐ Bi-polar disorder
☐ Obsessive compulsive disorder ☐ Eating disorder

L. **Allergies:** ☐ **Yes** ☐ **No**

☐ Allergies in any form ☐ Hay fever ☐ Hives ☐ Anaphylaxis

M. **Eye Conditions/Disorders:** ☐ **Yes** ☐ **No**

☐ Glaucoma ☐ Cataracts ☐ Strabismus (crossed eyes) ☐ Detached retina

N. **Ear Conditions/Disorders:** ☐ **Yes** ☐ **No**

☐ Hearing disorder ☐ Ear infection ☐ Loss of hearing

O. **Nasal Conditions/Disorders:** ☐ **Yes** ☐ **No**

☐ Deviated septum ☐ Adenoiditis ☐ Sinusitis

P. **Throat Conditions/Disorders:** ☐ **Yes** ☐ **No**

☐ Tonsillitis ☐ Strep throat

Q. **Skin Conditions/Disorders:** ☐ **Yes** ☐ **No**

☐ Acne ☐ Psoriasis ☐ Eczema ☐ Keratosis ☐ Pre-cancerous lesions ☐ Herpes ☐ Melanoma

R. **Congenital Abnormalities/Developmental Disorders:** ☐ **Yes** ☐ **No**

- **Congenital Abnormality:** ☐ Cleft palate/lip ☐ Club foot ☐ Heart/lung/kidney defect or malformation
- **Developmental Disorder:** ☐ Pervasive development disorder ☐ Down's syndrome
  ☐ Autism spectrum disorder ☐ Learning disability

S. **Reproductive System Conditions/Disorders:** ☐ **Yes** ☐ **No**

- **Female:** ☐ Infertility ☐ Abnormal menstrual bleeding ☐ Abnormal PAP smear ☐ Endometriosis
  ☐ Ovarian cyst ☐ Sexually transmitted disease ☐ Human papillomavirus (HPV)
  ☐ Pregnancy complications ☐ Uterine fibroid ☐ Breast infection or inflammation
- Is any female applicant currently pregnant, an expectant parent, or in the process of adopting?
  ☐ **Yes** ☐ **No**
- **Male:** ☐ Infertility ☐ Erectile dysfunction ☐ Sexually transmitted disease ☐ Prostate disorder
  ☐ Gynecomastia
- Is any male applicant an expectant parent or in the process of adopting? ☐ **Yes** ☐ **No**

T. **Other Conditions:** ☐ **Yes** ☐ **No**

Within the **past 5 years**, has anyone applying for coverage been diagnosed with, had treatment or testing recommended, received treatment, including prescription medications, or been hospitalized for **any illness, injury, or health condition not indicated elsewhere in this application?**

Note: You must include any illness, injury, or health condition related to one of the categories above, even if your specific illness, injury, or condition is not listed above.

PRIMARY APPLICANT NAME _____ DATE _____

DEPENDENT NAME (If submitted separately) _____

Within the past FIVE (5) YEARS:		
2 Has anyone applying for coverage received treatment or had treatment recommended for drug or alcohol abuse, or been convicted of a drug or alcohol related offense (including a DUI)?	☐ Yes	☐ No
3 **Other than indicated elsewhere on this application**, has anyone applying for coverage had an implant (e.g., breast, chin, or penile implant), internal fixation (e.g., pins, plates, rods, screws), prosthesis, pacemaker, heart valve replacement, shunt, or monitoring device?	☐ Yes	☐ No
4 Has anyone applying for coverage had testing performed and are currently **waiting for results**, or been advised to have treatment, testing, counseling, therapy, or surgery which has **not yet been performed**?	☐ Yes	☐ No

Within the past TWELVE (12) MONTHS:		
5 Has anyone applying for coverage experienced unexpected weight gain or loss of more than 20 pounds?	☐ Yes	☐ No
6 Has anyone applying for coverage used any tobacco product (such as cigarettes, snuff, chewing tobacco, or any nicotine substitution product)? ▶ If yes, indicate who: ☐ Primary Applicant ☐ Spouse/Domestic Partner ☐ Dependent Children	☐ Yes	☐ No
7 Has anyone applying for coverage participated in any dangerous or extreme sport activities, including, but not limited to: organized automobile/motorcycle/powerboat racing, skydiving, bungee jumping, ultralight flying, scuba diving, hang gliding, or outdoor rock/mountain climbing?	☐ Yes	☐ No

If yes, indicate:

Who & Which Activity	When/How Often	Do you plan continued participation?
_____		☐ Yes ☐ No
_____		☐ Yes ☐ No
_____		☐ Yes ☐ No

8 **Other than indicated elsewhere on this application**, has any person applying for coverage **EVER** been treated, hospitalized, or had surgery for:	
◆ bypass?	☐ Yes ☐ No
◆ angioplasty?	☐ Yes ☐ No
◆ stent?	☐ Yes ☐ No
◆ aneurysm?	☐ Yes ☐ No
◆ valve replacement?	☐ Yes ☐ No
◆ cancer?	☐ Yes ☐ No
◆ stroke?	☐ Yes ☐ No
◆ congenital abnormality?	☐ Yes ☐ No
◆ organ or bone marrow transplant?	☐ Yes ☐ No

PRIMARY APPLICANT NAME _____ DATE _____

DEPENDENT NAME (If submitted separately) _____

9 For **EACH** person applying for coverage, complete the following information regarding his/her **last physical exam** (including checkups):

Self Name:_____ Exam Date (MM/YY):_____/_____ Routine preventive care/wellness visit? ☐ Y ☐ N

Spouse/Domestic Partner's Name: _____ Exam Date (MM/YY):_____/_____ Routine preventive care/wellness visit? ☐ Y ☐ N

Dependent's Name:_____ Exam Date (MM/YY):_____/_____ Routine preventive care/wellness visit? ☐ Y ☐ N

Dependent's Name:_____ Exam Date (MM/YY):_____/_____ Routine preventive care/wellness visit? ☐ Y ☐ N

Dependent's Name:_____ Exam Date (MM/YY):_____/_____ Routine preventive care/wellness visit? ☐ Y ☐ N

Dependent's Name:_____ Exam Date (MM/YY):_____/_____ Routine preventive care/wellness visit? ☐ Y ☐ N

10 For **EACH** person applying for coverage, provide the following current information regarding his/her **height and weight**:

Self Name:_____ Height (Feet/Inches):_____/_____ Weight (in pounds): _____

Spouse/Domestic Partner's Name:_____ Height (Feet/Inches):_____/_____ Weight (in pounds): _____

Dependent's Name:_____ Height (Feet/Inches):_____/_____ Weight (in pounds): _____

Dependent's Name:_____ Height (Feet/Inches):_____/_____ Weight (in pounds): _____

Dependent's Name:_____ Height (Feet/Inches):_____/_____ Weight (in pounds): _____

Dependent's Name:_____ Height (Feet/Inches):_____/_____ Weight (in pounds): _____

F Additional Information

If you answered "YES" to any of the questions in Section E, you must provide additional information below. For an example of how to fill out this section, please visit the Illinois Department of Insurance website at www.insurance.illinois.gov.

Attach a separate sheet for additional information if necessary.

Question Number: **Name of Individual:**

Condition/Diagnosis: _____

Treatment Received: _____

_____

Treatment ongoing? ☐ Yes ☐ No First & Last Treatment Date: _____

Additional tests or treatment recommended? _____

Medication Prescribed (if any): _____

_____ Currently taking medication? ☐ Yes ☐ No

Physician Name _____

Phone # (_____)_____ City & State _____

PRIMARY APPLICANT NAME ______________________________________ DATE _________________________

DEPENDENT NAME (If submitted separately) ____

Question Number: **Name of Individual:**

Condition/Diagnosis: ____

Treatment Received: ____

Treatment ongoing? ☐ Yes ☐ No First & Last Treatment Date: ____________________________

Additional tests or treatment recommended? ____

Medication Prescribed (if any): ____

____ Currently taking medication? ☐ Yes ☐ No

Physician Name ____

Phone # (_____________)__________________________ City & State ____________________________

Question Number: **Name of Individual:**

Condition/Diagnosis: ____

Treatment Received: ____

Treatment ongoing? ☐ Yes ☐ No First & Last Treatment Date: ____________________________

Additional tests or treatment recommended? ____

Medication Prescribed (if any): ____

____ Currently taking medication? ☐ Yes ☐ No

Physician Name ____

Phone # (_____________)__________________________ City & State ____________________________

Question Number: **Name of Individual:**

Condition/Diagnosis: ____

Treatment Received: ____

Treatment ongoing? ☐ Yes ☐ No First & Last Treatment Date: ____________________________

Additional tests or treatment recommended? ____

Medication Prescribed (if any): ____

____ Currently taking medication? ☐ Yes ☐ No

Physician Name ____

Phone # (_____________)__________________________ City & State ____________________________

Question Number: **Name of Individual:**

Condition/Diagnosis: ____

Treatment Received: ____

Treatment ongoing? ☐ Yes ☐ No First & Last Treatment Date: ____________________________

Additional tests or treatment recommended? ____

Medication Prescribed (if any): ____

____ Currently taking medication? ☐ Yes ☐ No

Physician Name ____

Phone # (_____________)__________________________ City & State ____________________________

PRIMARY APPLICANT NAME ____________________________________ DATE ________________________

DEPENDENT NAME (If submitted separately) ____

G Prescription Information within the Last Twelve (12) Months

Within the past 12 months, has anyone applying for coverage been prescribed medication (other than for the common cold or flu) that is **not indicated elsewhere in this application**? ☐ Yes ☐ No

Attach a separate sheet for additional information if necessary.

Name of Individual:

Name of Medication: ____

Reason for Taking: ____

First & Last Treatment Date: ________________________ Currently taking medication? ☐ Yes ☐ No

Physician Name: ____

Phone # (__________)______________________ City & State ________________________

Name of Individual:

Name of Medication: ____

Reason for Taking: ____

First & Last Treatment Date: ________________________ Currently taking medication? ☐ Yes ☐ No

Physician Name: ____

Phone # (__________)______________________ City & State ________________________

Name of Individual:

Name of Medication: ____

Reason for Taking: ____

First & Last Treatment Date: ________________________ Currently taking medication? ☐ Yes ☐ No

Physician Name: ____

Phone # (__________)______________________ City & State ________________________

Name of Individual:

Name of Medication: ____

Reason for Taking: ____

First & Last Treatment Date: ________________________ Currently taking medication? ☐ Yes ☐ No

Physician Name: ____

Phone # (__________)______________________ City & State ________________________

Name of Individual:

Name of Medication: ____

Reason for Taking: ____

First & Last Treatment Date: ________________________ Currently taking medication? ☐ Yes ☐ No

Physician Name: ____

Phone # (__________)______________________ City & State ________________________

PRIMARY APPLICANT NAME _____ DATE _____

AFFIRMATION

Signature – Adult applicants must sign this form below. Parent or guardian signature is required for applicants under the age of 18. **By signing this form, you certify the following**:

1. I have read this entire application or it has been read to me.
2. No independent producer, agent, or employee of the insurer can change any part of this application or waive the requirement that I answer all questions completely and accurately.
3. I understand that if I intentionally omit or provide false information on or in relation to this application, then this policy may be cancelled retroactively, in which case any claim I submit may not be paid by the insurer. I understand that if I intentionally omit or provide false information on or in relation to this application that I may face legal liability, including legal action based on fraud.
4. **All of the answers provided within this application are, to the best of my knowledge and belief, true and complete.** For more information, please visit the Illinois Department of Insurance's website at www.insurance.illinois.gov.

STATEMENT OF UNDERSTANDING

I understand and agree that:

- The information I have provided in this application will be used by the insurer to determine whether to extend coverage and the premium amount for such coverage.
- No coverage shall be in force until approved by the insurer. If approved, coverage will be in force as of the effective date determined by the insurer.
- This application will become part of the contract between the insurer and me.
- Except for a dependent up to the age of 19, coverage for preexisting medical conditions may be excluded or be subject to a waiting period of up to 24 months.
- I am entitled to a copy of this application and the Authorization to Use and Disclose Protected Health Information that is a part of this application upon request. I agree that a photographic copy shall be as valid as the original. A legible facsimile signature shall have the same force and effect as the original.
- I authorize the insurer to transmit the information contained herein electronically.

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

I. Protected Health Information

By signing this form, I authorize certain organizations and persons to use or disclose my protected health information. Protected health information includes, but is not limited to, hospital records, physician records, claim or benefit records, lab results, mental health records, as well as information regarding the use of drug, alcohol, HIV/AIDS, sexually transmitted disease, and reproductive health services. Protected health information may be written, oral, or electronic. This form does not permit the use or disclosure of psychotherapy notes.

II. Purpose of this Authorization Form

By signing this form, I authorize the use and disclosure of protected health information for the purposes of pre-enrollment underwriting or risk-rating of health insurance coverage, to determine eligibility for enrollment or benefits under a health plan, or to allow the insurer to conduct utilization review and quality improvement activities ("Purpose").

III. Entities Authorized to Use and Disclose My Protected Health Information

Insurers: I hereby authorize the following insurers, their reinsurers, and their legal representatives ("Insurers") to receive, use, and disclose my protected health information for the Purpose listed above:

(Please list below the names of all the insurers to whom you are submitting this application).

Insurer: _____ Insurer: _____ Insurer: _____

Insurer: _____ Insurer: _____ Insurer: _____

PRIMARY APPLICANT NAME _____ DATE _____

I authorize the Insurers to disclose my protected health information: between themselves, to reinsuring companies, and to insurance intermediaries or other persons or organizations performing business or legal services in connection with the Purpose above.

I further authorize any licensed physician, medical practitioner, health care provider, hospital, clinic, or other medical or medically related facility, insurance or reinsuring company, or other organization, institution, or person that has any record or knowledge of my health to disclose such information to the extent permitted by law to Insurers for the Purpose above.

I understand that protected health information described in this form may be used by, or disclosed to or by, organizations and persons who are not subject to federal or state privacy laws.

IV. Term of Authorization
I agree this Authorization shall be valid for two-and-one-half (2 ½) years from the latest signature date below.

V. Right to Revoke
I understand I may revoke this authorization at any time by giving advance written notice to Insurers. Revocation of this authorization form will not affect actions Insurers and others took in reliance on this form prior to the written notice of revocation.

If this application was taken over the phone or on the computer, I acknowledge that I, myself, have not actually signed this application but instead hereby authorize the insurance carrier to print "Electronically Acknowledged" on the signature line of the application and I agree that such printing shall be treated as a valid signature for all purposes of this form. I acknowledge that the insurance carrier has verified my identity for this purpose in accordance with any applicable law or regulation.

I HAVE READ AND CONSIDERED THE CONTENTS OF THIS FORM. BY SIGNING THIS FORM, I HEREBY AUTHORIZE THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

_____ Date _____
Primary Applicant (or Authorized Legal Representative) Signature

_____ Date _____
Spouse / Domestic Partner Signature (ONLY if to be insured)

_____ Date _____
Dependent Signature (ONLY if 18 or over and ONLY if to be insured)

_____ Date _____
Dependent Signature (ONLY if 18 or over and ONLY if to be insured)

_____ Date _____
Dependent Signature (ONLY if 18 or over and ONLY if to be insured)

_____ Date _____
Dependent Signature (ONLY if 18 or over and ONLY if to be insured)

*For assistance in completing this application, please contact your insurance agent or the insurance company directly. For information about your health insurance rights under state and federal law, and other resources, please contact the Illinois Department of Insurance's Office of Consumer Health Insurance, toll free at (877) 527-9431.

PRIMARY APPLICANT NAME _____ DATE _____

TO BE COMPLETED BY AGENT
I. Agent/Producer Information

I certify that:

1. All answers provided in this application were completed by or provided by the applicant.
2. I have reviewed this enrollment form to ensure that all required items have been completed.
3. I am not aware of any information not disclosed on this enrollment form relating to the health, habits, or reputation of any person listed on this enrollment form, which might have a bearing on the risk.

1. Producer/Writing Agent

Name:	ID#/Code:
Company:	Phone: ( )
Email:	
Producer Signature: Date Signed: (A faxed signature shall be valid as an original signature.)	

2. Agent/Managing Agent

Name:	ID#/Code:
Company:	Phone: ( )
Email:	
Agent Signature: Date Signed: (A faxed signature shall be valid as an original signature.)	

BlueCross BlueShield of Illinois

Experience. Wellness. Everywhere.®

BlueValue Advantage℠

With your choice of deductibles.

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. BlueValue Advantage Coverage — BlueValue Advantage 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 BlueValue Advantage plan will be greater when you use the services of participating Hospitals and Physicians.**

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

BASIC PROVISIONS	BLUEVALUE ADVANTAGE	
	Participating Provider Coverage	Non-Participating Provider Coverage
Deductible Per individual, per calendar year. (If two or more family members receive covered services as a result of injuries received in the same accident, only one Deductible will apply.) *Carryover Deductible* If an insured incurs covered expenses for the Deductible in the last three months of the calendar year, we will carry over that amount as credit toward the Deductible for the following calendar year.	$250★ $500★ $1,000★ $1,750★ $2,500★ $5,000★	
Family Aggregate Deductible Per family, per calendar year.	Equal to three times the individual Deductible	
Hospital Admission Deductible Per admission, per individual.	$0	$300★
Coinsurance The level of coverage provided by the plan after the calendar year Deductible has been satisfied.	80%	50%
Out-of-Pocket Expense Limit The amount of money an individual pays toward covered hospital and medical expenses during any one calendar year. Items asterisked (★) do not apply to the out-of-pocket expense limit.	$3,000	$6,000
Family Aggregate Out-of-Pocket Expense Limit Equal to three times the individual out-of-pocket limit, per family, per calendar year.	$9,000	$18,000

BASIC PROVISIONS	BLUEVALUE ADVANTAGE	
	In-Network Provider Coverage	Out-of-Network Provider Coverage
Inpatient/Outpatient Physician Medical/Surgical Services	80%	50%
Preventive Care Services Benefits will be provided for the following Covered Services and will not be subject to Coinsurance, deductible, Copayment or maximum when in-network providers are used: a. 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"); b. immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention ("CDC") with respect to the individual involved; c. 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 d. with respect to women, such additional preventive care and screenings, not described in item a above, as 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).	100%†	50%
Inpatient/Outpatient Hospital Services Includes surgery, pre-admission testing and services received in a skilled nursing facility, coordinated home care program and hospice. (For mental health coverage levels, please refer to mental health benefits on the next page.)	80%	50%
Inpatient/Outpatient Hospital Diagnostic Testing Includes, but not limited to, X-rays, lab tests, EKGs, ECGs, pathology services, pulmonary function studies, radioisotope tests, and electromyograms.	80%	50%
Physical, Occupational, and Speech Therapist Services (70 visits per calendar year for physical therapy; 45 visits per calendar year for occupational therapy; 30 visits per calendar year for speech therapy.)	80%★	50%★
Temporomandibular Joint Dysfunction and Related Disorders	80%★	50%★
Optional Maternity Coverage Inpatient/Outpatient Hospital services and Physician Medical/Surgical services. *When elected, maternity benefits will begin 365 days after the effective date of the maternity coverage.*	80%	50%
Outpatient Emergency Care (Accident or Illness) For both Hospital and Physician.	80% after you pay $75 copayment†	
Additional Surgical Opinion Program Following a recommendation for elective surgery, provides additional consultations and related diagnostic service by a Physician, as needed.	100%†	
Other Covered Services Ambulance services; services of a private duty nursing service (4 visits per month); naprapathic services rendered by a Naprapath ($1,000 per calendar year maximum★); oxygen and its administration; blood plasma; surgical dressings; casts and splints; and outpatient prescription drugs.	80%	

BASIC PROVISIONS		BLUEVALUE ADVANTAGE	
		Participating Provider Coverage	Non-Participating Provider Coverage
Mental Illness Treatment and Substance Abuse Rehabilitation Treatment			
Inpatient Care (30 Inpatient Hospital days per calendar year.)			
Physician		80%★	50%★
Hospital	First 14 days	60%★	50%★
	Thereafter	50%★	50%★
Outpatient Care (30 visits per calendar year combined annual maximum and 100 visits per lifetime maximum.)			
Physician and Hospital		50%★	50%★
Medical Services Advisory (MSA®) The MSA helps you maximize your benefits.		The Participating Provider is responsible for notifying MSA when services are rendered in a Participating Hospital.	The Policyholder is responsible for notifying MSA for Hospital admissions at Non-Participating and Non-Plan Hospitals. MSA notification is required within three business days for non-emergencies and within one business day or as soon as reasonably possible for emergencies and maternity admissions. If Policyholder does not notify MSA, Hospital benefits are reduced by $1,000.★
Mental Health Unit In order to maximize your benefits, the Policyholder is responsible for notifying the Mental Health Unit for ALL care related to mental health and substance abuse. In the event of an admission, for either mental illness or substance abuse, notification is required three days prior for non-emergencies and within 24 hours or as soon as reasonably possible for emergencies. Failure to contact the Mental Health Unit may result in a reduction of benefits of up to $1,000.★			

Benefits for covered services are provided at either the Eligible Charge or the Maximum Allowance. Consult the Policy for definitions and your financial responsibility.

Durable Medical Equipment (DME) providers, Orthotic providers and Prosthetic providers are participating providers. Please refer to your Policy Book for details.

★ *Does not apply to out-of-pocket expense limit.*

† *Deductible does not apply.*

IF USING A NON-PLAN PROVIDER... A $300 per Hospital admission Deductible will apply.* If using a Non-Plan Provider, benefits are reduced to 50%. However, Outpatient Hospital emergency care is paid at 80% after you pay a $75 copayment, regardless of your coverage level or whether services were received from a Participating, Non-Participating or Non-Plan Provider.

PRE-EXISTING CONDITIONS LIMITATION Pre-existing Conditions are those health conditions which were diagnosed or treated by a Provider during the 12 months prior to the coverage effective date, or for which symptoms existed which would cause an ordinarily prudent person to seek diagnosis or treatment. Any Pre-existing Condition will be subject to a waiting period of 365 days. This limitation does not apply to individuals under 19 years of age.

PREMIUMS We may change premium rates only if we do so on a class basis for all DB-49 HCSC policies. Premiums can be changed based on age, sex, and rating area.

GUARANTEED RENEWABILITY Coverage under this Policy will be terminated for nonpayment of premiums. In addition, Blue Cross and Blue Shield may terminate or refuse to renew this Policy only for the following reasons:

1. If every Policy that bears this Policy form number, DB-49 HCSC, is not renewed. If this should occur:
   a. Blue Cross and Blue Shield will give you at least 90 days prior to written notice.
   b. You may convert to any other individual policy Blue Cross and Blue Shield offers to the individual market.
2. In the event of an act, practice or omission that constitutes fraud or making an intentional misrepresentation of material fact on your application may result in rescission of coverage. Rescission is defined as a cancellation or discontinuance of coverage that has a retroactive effect. You will be provided with at least 30 days' advance written notice before you or your dependent's coverage may be rescinded, retroactive to the effective date of coverage.
3. If you no longer reside, live or work in an area for which Blue Cross and Blue Shield is authorized to do business. Blue Cross and Blue Shield will never terminate or refuse to renew this Policy because of the condition of your health. Blue Cross and Blue Shield may uniformly modify coverage provided by every Policy which bears this Policy form number only on the coverage Renewal Date.

Exclusions and Limitations:

Hospitalization, Services, and supplies which are not Medically Necessary; 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; Services or supplies that are furnished to you by the local, state, or federal government; 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 or dental practice; Investigational Services and Supplies, including all related services and supplies; Custodial Care Service; Routine physical examinations, unless specifically stated in this Policy; Services or supplies received during an Inpatient stay when the stay is primarily related to behavioral, social maladjustment, lack of discipline, or other antisocial actions which are not specifically the result of Mental Illness; Cosmetic Surgery and related services and supplies, except for the correction of congenital deformities or for conditions resulting from accidental injuries, scars, tumors, or diseases; Services or supplies for which you are not required to make payment or would have no legal obligation to pay if you did not have this or similar coverage; Charges for failure to keep a scheduled visit or charges for completion of a Claim form; Personal hygiene, comfort, or convenience items commonly used for other than medical purposes, such as air conditioners, humidifiers, physical fitness equipment, televisions, and telephones; Special braces, splints, specialized equipment, appliances, ambulatory apparatus, battery controlled implants, except as specifically mentioned in this Policy; 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; 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; Immunizations, unless otherwise stated in this Policy; Maintenance Occupational Therapy, Maintenance Physical Therapy, and Maintenance Speech Therapy; Speech Therapy when rendered for the treatment of psychosocial speech delay, behavioral problems (including impulsive behavior and impulsivity syndrome), attention disorder, conceptual handicap, or mental retardation; Hearing aids or examinations for the prescription or fitting of hearing aids; Diagnostic Service as part of routine physical examinations or check-ups, premarital examinations, determination of the refractive errors of the eyes, auditory problems, surveys, casefinding, research studies, screening, or similar procedures and studies, or tests which are Investigational, unless otherwise specified in this Policy; Procurement or use of prosthetic devices, special appliances, and surgical implants which are for cosmetic purposes, or unrelated to the treatment of a disease or injury; Services and supplies provided for the diagnosis and/or treatment of infertility including, but not limited to, Hospital services, Medical Care, therapeutic injection, fertility and other drugs, Surgery, artificial insemination, and all forms of in-vitro fertilization; Maternity Service, including related services and supplies, unless selected as an option (Complications of Pregnancy are covered as any other illness). Long Term Care; Inpatient Private Duty Nursing Service; Maintenance Care; Wigs (also referred to as cranial prosthesis); and Services and supplies rendered or provided for human organ or tissue transplants other than those specifically named in this Policy.

* *Does not apply to out-of-pocket expense limit.*

BlueCross BlueShield of Illinois

Experience. Wellness. Everywhere.®

(POLICY DB-43 HCSC)

SelectBlue®

With your choice of deductibles and participating provider coinsurance levels.

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. SelectBlue Coverage — SelectBlue 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 SelectBlue plan will be greater when you use the services of participating Hospitals and Physicians.**

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

BASIC PROVISIONS	SELECTBLUE	
	Participating Provider Coverage	Non-Participating Provider Coverage
Deductible Per individual, per calendar year. (If two or more family members receive covered services as a result of injuries received in the same accident, only one Deductible will apply.) *Carryover Deductible* If an insured incurs covered expenses for the Deductible in the last three months of the calendar year, we will carry over that amount as credit toward the Deductible for the following calendar year.	$0★ $250★ $500★ $1,000★ $2,500★ $5,000★	
Family Aggregate Deductible Per family, per calendar year.	Equal to three times the individual Deductible	
Hospital Admission Deductible Per admission, per individual.	$0	$300★
Coinsurance The level of coverage provided by the plan after the calendar year Deductible has been satisfied. You must select a level of participating provider coverage: 100% participating provider coverage, or 80% participating provider coverage	100% 80%	80% 60%
Out-of-Pocket Expense Limit The amount of money an individual pays toward covered hospital and medical expenses during any one calendar year. Deductibles, reduction in benefits applicable to the Medical Services Advisory and/or the Mental Health Unit, charges that exceed the Maximum Allowance or the Eligible Charges, and items asterisked (★) do not apply to the out-of-pocket expense limit.	$1,000	$4,000
Family Aggregate Out-of-Pocket Expense Limit Equal to three times the individual out-of-pocket limit, per family, per calendar year.	$3,000	$12,000

BASIC PROVISIONS	SELECTBLUE	
	Participating Provider Coverage	Non-Participating Provider Coverage
Outpatient Physician Medical/Surgical Services Covered services OTHER THAN surgery, therapy, and certain diagnostic services received in a provider's office, which are described immediately below.	100% after you pay $20 copayment per visit★†	80%
	100% after you pay $20 copayment per visit★†	60%
Surgery, therapy, and certain diagnostic services including MRI, CT scan, pulmonary function studies, cardiac catheterization, EEG, EKG, ECG, and Swan-Ganz catheterization.	100%	80%
	80%	60%
Inpatient Physician Medical/Surgical Services	100%	80%
	80%	60%
Preventive Care Services Benefits will be provided for the following Covered Services and will not be subject to Coinsurance, deductible, Copayment or maximum when in-network providers are used: a. 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"); b. immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention ("CDC") with respect to the individual involved; c. 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 d. with respect to women, such additional preventive care and screenings, not described in item a above, as 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).	100%†	100% Plan covered at 80% 80% Plan covered at 60%
Inpatient/Outpatient Hospital Services Includes surgery, pre-admission testing and services received in a skilled nursing facility, coordinated home care program and hospice. (For mental health coverage levels, please refer to mental health benefits on the next page.)	100%	80%
	80%	60%
Inpatient/Outpatient Hospital Diagnostic Testing Includes but not limited to X-rays, lab tests, EKGs, ECGs, pathology services, pulmonary function studies, radioisotope tests, and electromyograms.	100%	80%
	80%	60%
Physical, Occupational, and Speech Therapist Services (70 visits per calendar year for physical therapy; 45 visits per calendar year for occupational therapy; 30 visits per calendar year for speech therapy.)	100%	80%★
	80%★	60%★
Temporomandibular Joint Dysfunction and Related Disorders	100%	80%★
	80%★	60%★
Optional Maternity Coverage Inpatient/Outpatient Hospital services and Physician Medical/Surgical services. *When elected, maternity benefits will begin 365 days after the effective date of the maternity coverage.*	100%	80%
	80%	60%
Outpatient Emergency Care (Accident or Illness) For both Hospital and Physician.	100%†	
Additional Surgical Opinion Program Following a recommendation for elective surgery, provides additional consultations and related diagnostic service by a Physician, as needed.	100%†	

BASIC PROVISIONS	SELECTBLUE	
	Participating Provider Coverage	Non-Participating Provider Coverage
Other Covered Services Ambulance services; services of a private duty nursing service (4 visits per month); naprapathic services rendered by a Naprapath ($1,000 per calendar year maximum★); oxygen and its administration; blood plasma; surgical dressings; casts and splints.	80%	
Mental Illness Treatment and Substance Abuse Rehabilitation Treatment**		
Inpatient Care (30 Inpatient Hospital days per calendar year.)		
Physician	80%★	60%★
Hospital First 14 days	60%★	50%★
Thereafter	50%★	50%★
Outpatient Care (30 visits per calendar year combined annual maximum and 100 visits per lifetime maximum.)		
Physician and Hospital	50%★	50%★

Medical Services Advisory (MSA®) In order to maximize your benefits, the Policyholder is responsible for notifying the MSA for Hospital admissions at Non-Participating and Non-Plan Hospitals. (MSA notification by the Policyholder is NOT required when services are rendered in a Participating Hospital.) MSA notification is required within three business days for non-emergencies and within one business day for emergencies and maternity admissions. Failure to contact the MSA will result in a reduction of Hospital benefits of $1,000.★

Mental Health Unit In order to maximize your benefits, the Policyholder is responsible for notifying the Mental Health Unit for ALL care related to mental health and substance abuse. In the event of an admission, for either mental illness or substance abuse, notification is required three days prior for non-emergencies and within 24 hours for emergencies. Failure to contact the Mental Health Unit may result in a reduction of benefits of up to $1,000.★

OUTPATIENT PRESCRIPTION DRUG BENEFIT	YOU PAY	SELECTBLUE PAYS
	Participating Pharmacy††	Participating Pharmacy††
$0, $250 and $500 Deductible plans ONLY		
• Generic	$10 copayment★	100%
• Brand formulary & Insulin and Insulin syringes	35%★	65%
• Brand non-formulary	50%★	50%
($100 out-of-pocket maximum per prescription.)		
Home Delivery: Up to a 90-day supply of maintenance drugs is available through home delivery and is subject to $300 out-of-pocket maximum per prescription.		
$1,000, $2,500 and $5,000 Deductible plans ONLY (Subject to deductible and coinsurance.)	20%	80%

Benefits for covered services are provided at either the Eligible Charge or the Maximum Allowance. Consult the Policy for definitions and your financial responsibility.

Durable Medical Equipment (DME) providers, Orthotic providers and Prosthetic providers are participating providers. Please refer to your Policy Book for details

★ *Does not apply to out-of-pocket expense limit.*

** *In order to receive benefits for Substance Abuse Care (other than Alcoholism), the treatment program must be approved by Blue Cross and Blue Shield of Illinois. Contact the Mental Health Unit for additional details.*

† *Deductible does not apply.*

†† *Benefits will be significantly reduced if you use a non-participating pharmacy.*

IF USING A NON-PLAN PROVIDER... A $300 per Hospital admission Deductible will apply.* If using a Non-Plan Provider, benefits are reduced to 50%. However, with the exception of Alcoholism, no benefits are available for Substance Abuse Rehabilitation Treatment. Also, Outpatient Hospital and Physician emergency care and additional surgical opinions are paid at 100%, regardless of the coverage level or Provider selected.

PRE-EXISTING CONDITIONS LIMITATION Pre-existing Conditions are those health conditions which were diagnosed or treated by a Provider during the 12 months prior to the coverage effective date, or for which symptoms existed which would cause an ordinarily prudent person to seek diagnosis or treatment. Any Pre-existing Condition will be subject to a waiting period of 365 days. This limitation does not apply to individuals under 19 years of age.

PREMIUMS We may change premium rates only if we do so on a class basis for all DB-43 HCSC policies. Premiums can be changed based on age, sex, and rating area.

GUARANTEED RENEWABILITY Coverage under this Policy will be terminated for nonpayment of premiums. In addition, Blue Cross and Blue Shield may terminate or refuse to renew this Policy only for the following reasons:

1. If every Policy that bears this Policy form number, DB-43 HCSC, is not renewed. If this should occur:
   a. Blue Cross and Blue Shield will give you at least 90 days prior to written notice.
   b. You may convert to any other individual policy Blue Cross and Blue Shield offers to the individual market.
2. In the event of an act, practice or omission that constitutes fraud or making an intentional misrepresentation of material fact on your application may result in rescission of coverage. Rescission is defined as a cancellation or discontinuance of coverage that has a retroactive effect. You will be provided with at least 30 days' advance written notice before you or your dependent's coverage may be rescinded, retroactive to the effective date of coverage.
3. If you no longer reside, live or work in an area for which Blue Cross and Blue Shield is authorized to do business. Blue Cross and Blue Shield will never terminate or refuse to renew this Policy because of the condition of your health. Blue Cross and Blue Shield may uniformly modify coverage provided by every Policy which bears this Policy form number only on the coverage Renewal Date.

Exclusions and Limitations:

Hospitalization, Services, and supplies which are not Medically Necessary; 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 except where not required by law; Services or supplies that are furnished to you by the local, state, or federal government; 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 or dental practice; Investigational Services and Supplies, including all related services and supplies; Custodial Care Service; Routine physical examinations, unless specifically stated in this Policy; Services or supplies received during an Inpatient stay when the stay is primarily related to behavioral, social maladjustment, lack of discipline, or other antisocial actions which are not specifically the result of Mental Illness; Cosmetic Surgery and related services and supplies, except for the correction of congenital deformities or for conditions resulting from accidental injuries, scars, tumors, or diseases; Services or supplies for which you are not required to make payment or would have no legal obligation to pay if you did not have this or similar coverage; Charges for failure to keep a scheduled visit or charges for completion of a Claim form; Personal hygiene, comfort, or convenience items commonly used for other than medical purposes, such as air conditioners, humidifiers, physical fitness equipment, televisions, and telephones; Special braces, splints, specialized equipment, appliances, ambulatory apparatus, battery controlled implants, except as specifically mentioned in this Policy; 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; 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; Immunizations, unless otherwise stated in this Policy; Maintenance Occupational Therapy, Maintenance Physical Therapy, and Maintenance Speech Therapy; Speech Therapy when rendered for the treatment of psychosocial speech delay, behavioral problems (including impulsive behavior and impulsivity syndrome), attention disorder, conceptual handicap, or mental retardation; Hearing aids or examinations for the prescription or fitting of hearing aids; Diagnostic Service as part of routine physical examinations or check-ups, premarital examinations, determination of the refractive errors of the eyes, auditory problems, surveys, casefinding, research studies, screening, or similar procedures and studies, or tests which are Investigational, unless otherwise specified in this Policy; Procurement or use of prosthetic devices, special appliances, and surgical implants which are for cosmetic purposes, or unrelated to the treatment of a disease or injury; Services and supplies provided for the diagnosis and/or treatment of infertility including, but not limited to, Hospital services, Medical Care, therapeutic injection, fertility and other drugs, Surgery, artificial insemination, and all forms of in-vitro fertilization; Maternity Service, including related services and supplies, unless selected as an option (Complications of Pregnancy are covered as any other illness).

* *Does not apply to out-of-pocket expense limit.*

BlueCross BlueShield of Illinois

Experience. Wellness. Everywhere.®

Blue*Choice*℠ Select

With your choice of deductibles.

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. Blue*Choice* Select Coverage — Blue*Choice* Select 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 Blue*Choice* Select plan will be greater when you use the services of designated Hospitals and Physicians.**

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

BASIC PROVISIONS	BLUE*CHOICE* SELECT	
	In-Network Provider Coverage	Out-of-Network Provider Coverage
Deductible Per individual, per calendar year. (If two or more family members receive covered services as a result of injuries received in the same accident, only one Deductible will apply.) *Carryover Deductible* If an insured incurs covered expenses for the Deductible in the last three months of the calendar year, we will carry over that amount as credit toward the Deductible for the following calendar year.	$250★ $500★ $1,000★ $1,750★ $2,500★ $5,000★	$750★ $1,500★ $3,000★ $5,250★ $7,500★ $15,000★
Family Aggregate Deductible Per family, per calendar year.	Equal to two times the individual Deductible	
Hospital Admission Deductible Per admission, per individual.	$0	$300★
Coinsurance The level of coverage provided by the plan after the calendar year Deductible has been satisfied.	80%	50%
Out-of-Pocket Expense Limit The amount of money an individual pays toward covered hospital and medical expenses during any one calendar year. Items asterisked (★) do not apply to the out-of-pocket expense limit.	$3,000	$6,000
Family Aggregate Out-of-Pocket Expense Limit Equal to two times the individual out-of-pocket limit, per family, per calendar year.	$6,000	$12,000

BASIC PROVISIONS	BLUE*CHOICE* SELECT	
	In-Network Provider Coverage	Out-of-Network Provider Coverage
Outpatient Physician Medical/Surgical Services Covered services OTHER THAN surgery, therapy, and certain diagnostic services received in a provider's office, which are described immediately below	100% after you pay $30 copayment per visit★†	50%
Surgery, therapy, and certain diagnostic services including MRI, CT scan, pulmonary function studies, cardiac catheterization, EEG, EKG, ECG, and swan ganz catheterization.	80%	50%
Inpatient Physician Medical/Surgical Services	80%	50%
Preventive Care Services Benefits will be provided for the following Covered Services and will not be subject to Coinsurance, deductible, Copayment or maximum when in-network providers are used: a. 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"); b. immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention ("CDC") with respect to the individual involved; c. 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 d. with respect to women, such additional preventive care and screenings, not described in item a above, as 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).	100%†	50%
Inpatient/Outpatient Hospital Services Includes surgery, pre-admission testing and services received in a skilled nursing facility, coordinated home care program and hospice. (For mental health coverage levels, please refer to mental health benefits on the next page.)	80%	50%
Inpatient/Outpatient Hospital Diagnostic Testing Includes, but not limited to, X-rays, lab tests, EKGs, ECGs, pathology services, pulmonary function studies, radioisotope tests, and electromyograms	80%	50%
Physical, Occupational, and Speech Therapist Services (70 visits per calendar year for physical therapy; 45 visits per calendar year for occupational therapy; 30 visits per calendar year for speech therapy.)	80%★	50%★
Temporomandibular Joint Dysfunction and Related Disorders	80%★	50%★
Optional Maternity Coverage Inpatient/Outpatient Hospital services and Physician Medical/Surgical services. *When elected, maternity benefits will begin 365 days after the effective date of the maternity coverage.*	80%	50%
Outpatient Emergency Care (Accident or Illness) For both Hospital and Physician.	80% after you pay $75 copayment†	
Additional Surgical Opinion Program Following a recommendation for elective surgery, provides additional consultations and related diagnostic service by a Physician, as needed.	100%†	

BASIC PROVISIONS	BLUE*CHOICE* SELECT	
	In-Network Provider Coverage	Out-of-Network Provider Coverage
Other Covered Services Ambulance services; services of a private duty nursing service (4 visits per month); naprapathic services rendered by a Naprapath ($1,000 per calendar year maximum★); oxygen and its administration; blood plasma; surgical dressings; casts and splints.	80%	
Mental Illness Treatment and Substance Abuse Rehabilitation Treatment		
Inpatient Care (30 Inpatient Hospital days per calendar year.)		
Physician	80%★	50%★
Hospital First 14 days	60%★	50%★
Thereafter	50%★	50%★
Outpatient Care (30 visits per calendar year combined annual maximum and 100 visits per lifetime maximum.)		
Physician and Hospital	50%★	50%★

Medical Services Advisory (MSA®) In order to maximize your benefits, the Policyholder is responsible for notifying the MSA for Hospital admissions at Out-of-Network and Non-Plan Hospitals. (MSA notification by the Policyholder is NOT required when services are rendered in a In-Network Hospital.) MSA notification is required within three business days for non-emergencies and within one business day or as soon as reasonably possible for emergencies and maternity admissions. Failure to contact the MSA will result in a reduction of Hospital benefits of $1,000.★

Mental Health Unit In order to maximize your benefits, the Policyholder is responsible for notifying the Mental Health Unit for ALL care related to mental health and substance abuse. In the event of an admission, for either mental illness or substance abuse, notification is required three days prior for non-emergencies and within 24 hours or as soon as reasonably possible for emergencies. Failure to contact the Mental Health Unit may result in a reduction of benefits of up to $1,000.★

OUTPATIENT PRESCRIPTION DRUG BENEFIT	YOU PAY	BLUE*CHOICE* SELECT PAYS
	Participating Pharmacy††	Participating Pharmacy††
$250 and $500 Deductible plans ONLY		
• Generic	$10 copayment★	100%
• Brand formulary & Insulin and Insulin syringes	35%★	65%
• Brand non-formulary	50%★	50%
($100 out-of-pocket maximum per prescription.)		
Home Delivery: Up to a 90-day supply of maintenance drugs is available through home delivery and is subject to $300 out-of-pocket maximum per prescription.		
• Generic	$20 copayment★	100%
• Brand formulary & Insulin and Insulin syringes	35%★	65%
• Brand non-formulary	50%★	50%
$1,000, $1,750, $2,500, and $5,000 Deductible plans ONLY (Subject to deductible and coinsurance.)	20%	80%

Benefits for covered services are provided at either the Eligible Charge or the Maximum Allowance. Consult the Policy for definitions and your financial responsibility.

Durable Medical Equipment (DME) providers, Orthotic providers and Prosthetic providers are participating providers. Please refer to your Policy Book for details.

★ *Does not apply to out-of-pocket expense limit.*

† *Deductible does not apply.*

†† *Benefits will be significantly reduced if you use a non-participating pharmacy.*

IF USING A NON PLAN PROVIDER... A $300 per Hospital admission Deductible will apply.* If using a Non-Plan Provider, benefits are reduced to 50%. However, Outpatient Hospital emergency care is paid at 80% after you pay a $75 copayment, regardless of your coverage level or whether services were received from an In-Network, Out-of-Network or Non-Plan Provider.

PRE-EXISTING CONDITIONS LIMITATION Pre-existing Conditions are those health conditions which were diagnosed or treated by a Provider during the 12 months prior to the coverage effective date, or for which symptoms existed which would cause an ordinarily prudent person to seek diagnosis or treatment. Any Pre-existing Condition will be subject to a waiting period of 365 days. This limitation does not apply to individuals under 19 years of age.

PREMIUMS We may change premium rates only if we do so on a class basis for all DB-46 HCSC policies. Premiums can be changed based on age, sex, and rating area.

GUARANTEED RENEWABILITY Coverage under this Policy will be terminated for nonpayment of premiums. In addition, Blue Cross and Blue Shield may terminate or refuse to renew this Policy only for the following reasons:

1. If every Policy that bears this Policy form number, DB-46 HCSC, is not renewed. If this should occur:
   a. Blue Cross and Blue Shield will give you at least 90 days prior to written notice.
   b. You may convert to any other individual policy Blue Cross and Blue Shield offers to the individual market.
2. In the event of an act, practice or omission that constitutes fraud or making an intentional misrepresentation of material fact on your application may result in rescission of coverage. Rescission is defined as a cancellation or discontinuance of coverage that has a retroactive effect. You will be provided with at least 30 days' advance written notice before you or your dependent's coverage may be rescinded, retroactive to the effective date of coverage.
3. If you no longer reside, live or work in an area for which Blue Cross and Blue Shield is authorized to do business. Blue Cross and Blue Shield will never terminate or refuse to renew this Policy because of the condition of your health. Blue Cross and Blue Shield may uniformly modify coverage provided by every Policy which bears this Policy form number only on the coverage Renewal Date.

Exclusions and Limitations:

Hospitalization, Services, and supplies which are not Medically Necessary; 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 except where not required by law; Services or supplies that are furnished to you by the local, state, or federal government; 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 or dental practice; Investigational Services and Supplies, including all related services and supplies; Custodial Care Service; Routine physical examinations, unless specifically stated in this Policy; Services or supplies received during an Inpatient stay when the stay is primarily related to behavioral, social maladjustment, lack of discipline, or other antisocial actions which are not specifically the result of Mental Illness; Cosmetic Surgery and related services and supplies, except for the correction of congenital deformities or for conditions resulting from accidental injuries, scars, tumors, or diseases; Services or supplies for which you are not required to make payment or would have no legal obligation to pay if you did not have this or similar coverage; Charges for failure to keep a scheduled visit or charges for completion of a Claim form; Personal hygiene, comfort, or convenience items commonly used for other than medical purposes, such as air conditioners, humidifiers, physical fitness equipment, televisions, and telephones; Special braces, splints, specialized equipment, appliances, ambulatory apparatus, battery controlled implants, except as specifically mentioned in this Policy; 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; 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; Immunizations, unless otherwise stated in this Policy; Maintenance Occupational Therapy, Maintenance Physical Therapy, and Maintenance Speech Therapy; Speech Therapy when rendered for the treatment of psychosocial speech delay, behavioral problems (including impulsive behavior and impulsivity syndrome), attention disorder, conceptual handicap, or mental retardation; Hearing aids or examinations for the prescription or fitting of hearing aids; Diagnostic Service as part of routine physical examinations or check-ups, premarital examinations, determination of the refractive errors of the eyes, auditory problems, surveys, casefinding, research studies, screening, or similar procedures and studies, or tests which are Investigational, unless otherwise specified in this Policy; Procurement or use of prosthetic devices, special appliances, and surgical implants which are for cosmetic purposes, or unrelated to the treatment of a disease or injury; Services and supplies provided for the diagnosis and/or treatment of infertility including, but not limited to, Hospital services, Medical Care, therapeutic injection, fertility and other drugs, Surgery, artificial insemination, and all forms of in-vitro fertilization; Maternity Service, including related services and supplies, unless selected as an option (Complications of Pregnancy are covered as any other illness). Long Term Care; Inpatient Private Duty Nursing Service; Maintenance Care; Wigs (also referred to as cranial prosthesis); and Services and supplies rendered or provided for human organ or tissue transplants other than those specifically named in this Policy.

* *Does not apply to out-of-pocket expense limit.*

BlueCross BlueShield of Illinois

Experience. Wellness. Everywhere.®

Blue*Choice*℠ Value

With your choice of deductibles.

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. Blue*Choice* Value Coverage — Blue*Choice* Value 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 Blue*Choice* Value plan will be greater when you use the services of designated Hospitals and Physicians.**

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

BASIC PROVISIONS	BLUE*CHOICE* VALUE	
	In-Network Provider Coverage	Out-of-Network Provider Coverage
Deductible Per individual, per calendar year. (If two or more family members receive covered services as a result of injuries received in the same accident, only one Deductible will apply.) *Carryover Deductible* If an insured incurs covered expenses for the Deductible in the last three months of the calendar year, we will carry over that amount as credit toward the Deductible for the following calendar year.	$250★ $500★ $1,000★ $1,750★ $2,500★ $5,000★	$750★ $1,500★ $3,000★ $5,250★ $7,500★ $15,000★
Family Aggregate Deductible Per family, per calendar year.	Equal to two times the individual Deductible	
Hospital Admission Deductible Per admission, per individual.	$0	$300★
Coinsurance The level of coverage provided by the plan after the calendar year Deductible has been satisfied.	80%	50%
Out-of-Pocket Expense Limit The amount of money an individual pays toward covered hospital and medical expenses during any one calendar year. Items asterisked (★) do not apply to the out-of-pocket expense limit.	$3,000	$6,000
Family Aggregate Out-of-Pocket Expense Limit Equal to two times the individual out-of-pocket limit, per family, per calendar year.	$6,000	$12,000

BASIC PROVISIONS	BLUE*CHOICE* VALUE	
	In-Network Provider Coverage	Out-of-Network Provider Coverage
Inpatient/Outpatient Physician Medical/Surgical Services	80%	50%
Preventive Care Services Benefits will be provided for the following Covered Services and will not be subject to Coinsurance, deductible, Copayment or maximum when in-network providers are used: a. 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"); b. immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention ("CDC") with respect to the individual involved; c. 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 d. with respect to women, such additional preventive care and screenings, not described in item a above, as 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).	100%†	50%
Inpatient/Outpatient Hospital Services Includes surgery, pre-admission testing and services received in a skilled nursing facility, coordinated home care program and hospice. (For mental health coverage levels, please refer to mental health benefits on the next page.)	80%	50%
Inpatient/Outpatient Hospital Diagnostic Testing Includes, but not limited to, X-rays, lab tests, EKGs, ECGs, pathology services, pulmonary function studies, radioisotope tests, and electromyograms.	80%	50%
Physical, Occupational, and Speech Therapist Services (70 visits per calendar year for physical therapy; 45 visits per calendar year for occupational therapy; 30 visits per calendar year for speech therapy.)	80%★	50%★
Temporomandibular Joint Dysfunction and Related Disorders	80%★	50%★
Optional Maternity Coverage Inpatient/Outpatient Hospital services and Physician Medical/Surgical services. *When elected, maternity benefits will begin 365 days after the effective date of the maternity coverage.*	80%	50%
Outpatient Emergency Care (Accident or Illness) For both Hospital and Physician.	80% after you pay $75 copayment†	
Additional Surgical Opinion Program Following a recommendation for elective surgery, provides additional consultations and related diagnostic service by a Physician, as needed.	100%†	
Other Covered Services Ambulance services; services of a private duty nursing service (4 visits per month); naprapathic services rendered by a Naprapath ($1,000 per calendar year maximum★); oxygen and its administration; blood plasma; surgical dressings; casts and splints; and outpatient prescription drugs.	80%	

BASIC PROVISIONS		BLUE*CHOICE* VALUE	
		In-Network Provider Coverage	Out-of-Network Provider Coverage
Mental Illness Treatment and Substance Abuse Rehabilitation Treatment			
Inpatient Care (30 Inpatient Hospital days per calendar year.)			
Physician		80%★	50%★
Hospital	First 14 days	60%★	50%★
	Thereafter	50%★	50%★
Outpatient Care (30 visits per calendar year combined annual maximum and 100 visits per lifetime maximum.)			
Physician and Hospital		50%★	50%★
Medical Services Advisory (MSA®) The MSA helps you maximize your benefits.		The In-Network Provider is responsible for notifying MSA when services are rendered in an In-Network Hospital.	The Policyholder is responsible for notifying MSA for Hospital admissions at Out-of-Network and Non-Plan Hospitals. MSA notification is required within three business days for non-emergencies and within one business day or as soon as reasonably possible for emergencies and maternity admissions. If Policyholder does not notify MSA, Hospital benefits are reduced by $1,000.★
Mental Health Unit In order to maximize your benefits, the Policyholder is responsible for notifying the Mental Health Unit for ALL care related to mental health and substance abuse. In the event of an admission, for either mental illness or substance abuse, notification is required three days prior for non-emergencies and within 24 hours or as soon as reasonably possible for emergencies. Failure to contact the Mental Health Unit may result in a reduction of benefits of up to $1,000.★			

Benefits for covered services are provided at either the Eligible Charge or the Maximum Allowance. Consult the Policy for definitions and your financial responsibility.

Durable Medical Equipment (DME) providers, Orthotic providers and Prosthetic providers are participating providers. Please refer to your Policy Book for details.

★ *Does not apply to out-of-pocket expense limit.*

† *Deductible does not apply.*

IF USING A NON-PLAN PROVIDER... A $300 per Hospital admission Deductible will apply.* If using a Non-Plan Provider, benefits are reduced to 50%. However, Outpatient Hospital emergency care is paid at 80% after you pay a $75 copayment, regardless of your coverage level or whether services were received from an In-Network, Out-of-Network or Non-Plan Provider.

PRE-EXISTING CONDITIONS LIMITATION Pre-existing Conditions are those health conditions which were diagnosed or treated by a Provider during the 12 months prior to the coverage effective date, or for which symptoms existed which would cause an ordinarily prudent person to seek diagnosis or treatment. Any Pre-existing Condition will be subject to a waiting period of 365 days. This limitation does not apply to individuals under 19 years of age.

PREMIUMS We may change premium rates only if we do so on a class basis for all DB-47 HCSC policies. Premiums can be changed based on age, sex, and rating area.

GUARANTEED RENEWABILITY Coverage under this Policy will be terminated for nonpayment of premiums. In addition, Blue Cross and Blue Shield may terminate or refuse to renew this Policy only for the following reasons:

1. If every Policy that bears this Policy form number, DB-47 HCSC, is not renewed. If this should occur:
   a. Blue Cross and Blue Shield will give you at least 90 days prior to written notice.
   b. You may convert to any other individual policy Blue Cross and Blue Shield offers to the individual market.
2. In the event of an act, practice or omission that constitutes fraud or making an intentional misrepresentation of material fact on your application may result in rescission of coverage. Rescission is defined as a cancellation or discontinuance of coverage that has a retroactive effect. You will be provided with at least 30 days' advance written notice before you or your dependent's coverage may be rescinded, retroactive to the effective date of coverage.
3. If you no longer reside, live or work in an area for which Blue Cross and Blue Shield is authorized to do business. Blue Cross and Blue Shield will never terminate or refuse to renew this Policy because of the condition of your health. Blue Cross and Blue Shield may uniformly modify coverage provided by every Policy which bears this Policy form number only on the coverage Renewal Date.

Exclusions and Limitations:

Hospitalization, Services, and supplies which are not Medically Necessary; 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; Services or supplies that are furnished to you by the local, state, or federal government; 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 or dental practice; Investigational Services and Supplies, including all related services and supplies; Custodial Care Service; Routine physical examinations, unless specifically stated in this Policy; Services or supplies received during an Inpatient stay when the stay is primarily related to behavioral, social maladjustment, lack of discipline, or other antisocial actions which are not specifically the result of Mental Illness; Cosmetic Surgery and related services and supplies, except for the correction of congenital deformities or for conditions resulting from accidental injuries, scars, tumors, or diseases; Services or supplies for which you are not required to make payment or would have no legal obligation to pay if you did not have this or similar coverage; Charges for failure to keep a scheduled visit or charges for completion of a Claim form; Personal hygiene, comfort, or convenience items commonly used for other than medical purposes, such as air conditioners, humidifiers, physical fitness equipment, televisions, and telephones; Special braces, splints, specialized equipment, appliances, ambulatory apparatus, battery controlled implants, except as specifically mentioned in this Policy; 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; 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; Immunizations, unless otherwise stated in this Policy; Maintenance Occupational Therapy, Maintenance Physical Therapy, and Maintenance Speech Therapy; Speech Therapy when rendered for the treatment of psychosocial speech delay, behavioral problems (including impulsive behavior and impulsivity syndrome), attention disorder, conceptual handicap, or mental retardation; Hearing aids or examinations for the prescription or fitting of hearing aids; Diagnostic Service as part of routine physical examinations or check-ups, premarital examinations, determination of the refractive errors of the eyes, auditory problems, surveys, casefinding, research studies, screening, or similar procedures and studies, or tests which are Investigational, unless otherwise specified in this Policy; Procurement or use of prosthetic devices, special appliances, and surgical implants which are for cosmetic purposes, or unrelated to the treatment of a disease or injury; Services and supplies provided for the diagnosis and/or treatment of infertility including, but not limited to, Hospital services, Medical Care, therapeutic injection, fertility and other drugs, Surgery, artificial insemination, and all forms of in-vitro fertilization; Maternity Service, including related services and supplies, unless selected as an option (Complications of Pregnancy are covered as any other illness). Long Term Care; Inpatient Private Duty Nursing Service; Maintenance Care; Wigs (also referred to as cranial prosthesis); and Services and supplies rendered or provided for human organ or tissue transplants other than those specifically named in this Policy.

* *Does not apply to out-of-pocket expense limit.*

BlueCross BlueShield of Illinois

Experience. Wellness. Everywhere.®

BlueEdge℠ Individual HSA
BlueEdge℠ Individual HSA 5000

With Your Choice of Deductibles, Participating Provider Coinsurance Levels, and Provider Networks.

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. BlueEdge Individual HSA Coverage — BlueEdge Individual HSA 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, Inpatient Hospital medical services and Outpatient Hospital care, subject to any deductibles 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 BlueEdge Individual HSA plan will be greater when you use the services of Participating/In-network Hospitals and Physicians.**

BASIC PROVISIONS	BlueEdge Individual HSA BlueEdge Individual HSA 5000	
	Participating Provider Coverage	**Non-Participating Provider Coverage**
Network You must select a network.	PPO Network Blue*Choice*℠ Network	
Individual Coverage Deductible Per calendar year.	$1,200†, $1,750, $2,600, $3.500, $5,000	
Family Coverage Deductible Per calendar year.	Equal to two times the individual deductible	
Hospital Admission Deductible Per admission, per individual.	$0	$300
Coinsurance The level of coverage provided by the plan after the calendar-year Deductible has been satisfied. You must select a level of participating provider coverage 100% participating provider coverage, or 80% participating provider coverage	100% 80%**	80% 60%**
Individual Out-of-Pocket Expense Limit The amount of money an individual pays toward covered hospital and medical expenses during any one calendar year. $5,000 Deductible Option	Calendar year deductible plus $3,000* Your calendar year deductible	Calendar year deductible plus $6,000 Your calendar year deductible plus $5,000
Family Aggregate Out-of-Pocket Expense Limit Equal to two times the individual out-of-pocket limit, per family, per calendar year. $5,000 Deductible Option	Calendar year deductible plus $6,000* Your calendar year deductible	Calendar year deductible plus $12,000 Your calendar year deductible plus $10,000

BASIC PROVISIONS	BlueEdge Individual HSA BlueEdge Individual HSA 5000	
	Participating Provider Coverage	Non-Participating Provider Coverage
Inpatient/Outpatient Physician Medical/Surgical Services	100% 80%**	80% 60%**
Preventive Care Services Benefits will be provided for the following Covered Services and will not be subject to Coinsurance, deductible, Copayment or benefit 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 the 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).	100%	
Inpatient/Outpatient Hospital Services Includes surgery, preadmission testing and services received in a skilled nursing facility, coordinated home care program and hospice. (For mental health coverage levels, please refer to mental health benefits on the next page.)	100% 80%**	80% 60%**
Inpatient/Outpatient Hospital Diagnostic Services Includes, but not limited to, X-rays, lab tests, EKGs, ECGs, pathology services, pulmonary function studies, radioisotope tests and electromyograms.	100% 80%**	80% 60%**
Physical, Occupational, and Speech Therapist Services	100% 80%**	80% 60%**
Temporomandibular Joint Dysfunction and Related Disorders	100% 80%**	80% 60%**
Muscle Manipulations Rendered by a Physician or Chiropractor ($1,000 per calendar year.)	100% 80%**	80% 60%**
Optional Maternity Coverage Inpatient/Outpatient Hospital services and Physician Medical/Surgical services. *When elected, maternity benefits will begin 365 days after the effective date of the maternity coverage.*	100% 80%**	80% 60%**
Outpatient Emergency Care (Accident or Illness) For both Hospital and Physician.	100% 80%**	
Additional Surgical Opinion Program Following a recommendation for elective surgery, provides additional consultations and related diagnostic service by a Physician, as needed.	100%	80%
Other Covered Services Ambulance services; services of a private duty nursing service; naprapathic services rendered by a Naprapath ($1,000 per calendar-year maximum); oxygen and its administration; blood plasma; surgical dressings; casts and splints.	100% 80%**	

BASIC PROVISIONS	BlueEdge Individual HSA BlueEdge Individual HSA 5000	
	Participating Provider Coverage	Non-Participating Provider Coverage
Outpatient Prescription Drugs	100% 80%**	
Mental Illness Treatment and Substance Abuse Rehabilitation Treatment		
Inpatient Care (30 Inpatient Hospital days per calendar year.)		
Physician	100% 80%**	80% 60%**
Hospital First 14 days	60%	50%
Thereafter	50%	50%
$5,000 Deductible Option	100%	50%
Outpatient Care (30 visits per calendar year combined annual maximum)		
Physician and Hospital	50%	50%
$5,000 Deductible Option	100%	50%
Medical Services Advisory (MSA®) The MSA helps you maximize your benefits.	The Participating Provider is responsible for notifying MSA when services are rendered in a Participating Hospital.	The Policyholder is responsible for notifying MSA for Hospital admissions at Non-Participating and and Non-Plan Hospitals. MSA notification is required within three business days for non-emergencies and within one business day or as soon as reasonably possible for emergencies and maternity admissions. If Policyholder does not notify MSA, the Policyholder will then be responsible for the first $1,000 or 50% of the Hospital charge, whichever is less.

Mental Health Unit In order to maximize your benefits, the Policyholder is responsible for notifying the Mental Health Unit for ALL care related to mental health and substance abuse. In the event of an admission, for either mental illness or substance abuse, notification is required three days prior for non-emergencies and within 24 hours or as soon as reasonably possible for emergencies. If the Policyholder does not notify the Mental Health Unit, the Policyholder will then be responsible for the first $1,000 or 50% of the Hospital charge, whichever is less.

Durable Medical Equipment (DME) providers, Orthotic providers and Prosthetic providers are participating providers. Please refer to your Policy Book for details.

★ The individual out-of-pocket expense plus individual deductible can not exceed $5,000. The family aggregate out-of-pocket expense plus family deductible can not exceed $10,000.

★★ Not available with $5,000 Deductible Option

† The deductible amount will be adjusted automatically if the amount is lower than the amount required by law.

†† Deductible does not apply

IF USING A NON-PLAN PROVIDER... A $300 per Hospital admission Deductible will apply. If using a Non-Plan Provider, benefits are reduced to 50%. However, Outpatient Hospital emergency care is paid at 80% or 100% depending on the plan, regardless of where you receive services.

PRE-EXISTING CONDITIONS LIMITATION Pre-existing Conditions are those health conditions which were diagnosed or treated by a Provider during the 12 months prior to the coverage effective date, or for which symptoms existed which would cause an ordinarily prudent person to seek diagnosis or treatment. Any Pre-existing Condition will be subject to a waiting period of 365 days. This limitation does not apply to dependent children under 19 years of age.

PREMIUMS We may change premium rates only if we do so on a class basis for all DB-50/DB-51/DB-56/DB-57 HCSC policies. Premiums can be changed based on age, sex and rating area.

COST OF LIVING ADJUSTMENT (COLA) The deductible and/or out-of-pocket expense amounts may be adjusted for inflation based on the Consumer Price Index or other index used by the Federal Government and rounded up to the nearest $50 increment.

GUARANTEED RENEWABILITY Coverage under this Policy will be terminated for nonpayment of premiums. In addition, Blue Cross and Blue Shield may terminate or refuse to renew this Policy only for the following reasons:

1. If every Policy that bears these Policy form numbers, DB-50/DB-51/DB-56/DB-57 HCSC, are not renewed. If this should occur:
   a. Blue Cross and Blue Shield will give you at least 90 days prior to written notice.
   b. You may convert to any other individual policy Blue Cross and Blue Shield offers to the individual market.
2. In the event of fraud or an intentional misrepresentation of material fact under the terms of this Policy. In this case, Blue Cross and Blue Shield will give you at least thirty (30) days prior written notice.
3. If you no longer reside, live or work in an area for which Blue Cross and Blue Shield is authorized to do business. Blue Cross and Blue Shield will never terminate or refuse to renew this Policy because of the condition of your health. Blue Cross and Blue Shield may uniformly modify coverage provided by every Policy which bears these Policy form numbers only on the coverage Renewal Date.

Please be reminded that Health Savings Accounts (HSA) have tax and legal ramifications. Health Care Service Corporation, d/b/a Blue Cross and Blue Shield of Illinois, does not provide legal or tax advice, and nothing herein should be construed as legal or tax advice. Please consult your tax advisors for information regarding the tax consequences of specific health insurance plans or products.

Exclusions and Limitations:

Hospitalization, Services, and supplies which are not Medically Necessary; 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 except where not required by law; Services or supplies that are furnished to you by the local, state, or federal government; 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 or dental practice; Investigational Services and Supplies, including all related services and supplies; Custodial Care Service; Routine physical examinations, unless specifically stated in this Policy; Services or supplies received during an Inpatient stay when the stay is primarily related to behavioral, social maladjustment, lack of discipline, or other antisocial actions which are not specifically the result of Mental Illness; Cosmetic Surgery and related services and supplies, except for the correction of congenital deformities or for conditions resulting from accidental injuries, scars, tumors, or diseases; Services or supplies for which you are not required to make payment or would have no legal obligation to pay if you did not have this or similar coverage; Charges for failure to keep a scheduled visit or charges for completion of a Claim form; Personal hygiene, comfort, or convenience items commonly used for other than medical purposes, such as air conditioners, humidifiers, physical fitness equipment, televisions, and telephones; Special braces, splints, specialized equipment, appliances, ambulatory apparatus, battery controlled implants, except as specifically mentioned in this Policy; 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; 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; Immunizations, unless otherwise stated in this Policy; Maintenance Occupational Therapy, Maintenance Physical Therapy, and Maintenance Speech Therapy, except as specifically mentioned in this Policy; Speech Therapy when rendered for the treatment of psychosocial speech delay, behavioral problems (including impulsive behavior and impulsivity syndrome), attention disorder, conceptual handicap, or mental retardation; Hearing aids or examinations for the prescription or fitting of hearing aids; Diagnostic Service as part of routine physical examinations or check-ups, premarital examinations, determination of the refractive errors of the eyes, auditory problems, surveys, casefinding, research studies, screening, or similar procedures and studies, or tests which are Investigational, unless otherwise specified in this Policy; Procurement or use of prosthetic devices, special appliances, and surgical implants which are for cosmetic purposes, or unrelated to the treatment of a disease or injury; Services and supplies provided for the diagnosis and/or treatment of infertility including, but not limited to, Hospital services, Medical Care, therapeutic injection, fertility and other drugs, Surgery, artificial insemination, and all forms of in-vitro fertilization; Maternity Service, including related services and supplies, unless selected as an option (Complications of Pregnancy are covered as any other illness); Long Term Care; Inpatient Private Duty Nursing Service; Maintenance Care; Wigs (also referred to as cranial prosthesis); and Services and supplies rendered or provided for human organ or tissue transplants other than those specifically named in this Policy.

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

BlueCross BlueShield of Illinois

Experience. Wellness. Everywhere.®

BlueValue℠

With your choice of deductibles and participating provider coinsurance levels.

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. BlueValue Coverage — BlueValue 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 BlueValue plan will be greater when you use the services of participating Hospitals and Physicians.**

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

BASIC PROVISIONS	BLUEVALUE	
	Participating Provider Coverage	Non-Participating Provider Coverage
Deductible Per individual, per calendar year. (If two or more family members receive covered services as a result of injuries received in the same accident, only one Deductible will apply.) *Carryover Deductible* If an insured incurs covered expenses for the Deductible in the last three months of the calendar year, we will carry over that amount as credit toward the Deductible for the following calendar year.	\$250★ \$500★ \$1,000★ \$2,500★ \$5,000★	
Family Aggregate Deductible Per family, per calendar year.	Equal to three times the individual Deductible	
Hospital Admission Deductible Per admission, per individual.	\$0	\$300★
Coinsurance The level of coverage provided by the plan after the calendar year Deductible has been satisfied. You must select a level of participating provider coverage: 100% participating provider coverage, or 80% participating provider coverage	100% 80%	80% 60%
Out-of-Pocket Expense Limit The amount of money an individual pays toward covered hospital and medical expenses during any one calendar year. Deductibles, reduction in benefits applicable to the Medical Services Advisory and/or the Mental Health Unit, charges that exceed the Maximum Allowance or the Eligible Charges, and items asterisked (★) do not apply to the out-of-pocket expense limit.	\$1,000	\$4,000
Family Aggregate Out-of-Pocket Expense Limit Equal to three times the individual out-of-pocket limit, per family, per calendar year.	\$3,000	\$12,000

BASIC PROVISIONS	BLUEVALUE	
	Participating Provider Coverage	Non-Participating Provider Coverage
Inpatient/Outpatient Physician Medical/Surgical Services	100% 80%	80% 60%
Preventive Care Services Benefits will be provided for the following Covered Services and will not be subject to Coinsurance, deductible, Copayment or maximum when in-network providers are used: a. 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"); b. immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention ("CDC") with respect to the individual involved; c. 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 d. with respect to women, such additional preventive care and screenings, not described in item a above, as 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).	100%†	100% Plan covered at 80%
Inpatient/Outpatient Hospital Services Includes surgery, pre-admission testing and services received in a skilled nursing facility, coordinated home care program and hospice. (For mental health coverage levels, please refer to mental health benefits on the next page.)	100% 80%	80% 60%
Inpatient/Outpatient Hospital Diagnostic Testing Includes but not limited to X-rays, lab tests, EKGs, ECGs, pathology services, pulmonary function studies, radioisotope tests, and electromyograms.	100% 80%	80% 60%
Physical, Occupational, and Speech Therapist Services (70 visits per calendar year for physical therapy; 45 visits per calendar year for occupational therapy; 30 visits per calendar year for speech therapy.)	100% 80%★	80%★ 60%★
Temporomandibular Joint Dysfunction and Related Disorders	100% 80%★	80%★ 60%★
Optional Maternity Coverage Inpatient/Outpatient Hospital services and Physician Medical/Surgical services. *When elected, maternity benefits will begin 365 days after the effective date of the maternity coverage.*	100% 80%	80% 60%
Outpatient Emergency Care (Accident or Illness) For both Hospital and Physician.	100%†	
Additional Surgical Opinion Program Following a recommendation for elective surgery, provides additional consultations and related diagnostic service by a Physician, as needed.	100%†	
Other Covered Services Ambulance services; services of a private duty nursing service (4 visits per month); naprapathic services rendered by a Naprapath ($1,000 per calendar year maximum★); oxygen and its administration; blood plasma; surgical dressings; casts and splints; and outpatient prescription drugs.	80%	

BASIC PROVISIONS		BLUEVALUE	
		Participating Provider Coverage	Non-Participating Provider Coverage
Mental Illness Treatment and Substance Abuse Rehabilitation Treatment**			
Inpatient Care (30 Inpatient Hospital days per calendar year.)		100%	80%*
Physician		80%*	60%*
Hospital	First 14 days	60%*	50%*
	Thereafter	50%*	50%*
Outpatient Care (30 visits per calendar year combined annual maximum and 100 visits per lifetime maximum.)			
Physician and Hospital		50%*	50%*
Medical Services Advisory (MSA®) The MSA helps you maximize your benefits.		The Participating Provider is responsible for notifying MSA when services are rendered in a Participating Hospital.	The Policyholder is responsible for notifying MSA for Hospital admissions at Non-Participating and Non-Plan Hospitals. MSA notification is required within three business days for non-emergencies and within one business day for emergencies and maternity admissions. If Policyholder does not notify MSA, Hospital benefits are reduced by $1,000.*
Mental Health Unit In order to maximize your benefits, the Policyholder is responsible for notifying the Mental Health Unit for ALL care related to mental health and substance abuse. In the event of an admission, for either mental illness or substance abuse, notification is required three days prior for non-emergencies and within 24 hours for emergencies. Failure to contact the Mental Health Unit may result in a reduction of benefits of up to $1,000.*			

Benefits for covered services are provided at either the Eligible Charge or the Maximum Allowance. Consult the Policy for definitions and your financial responsibility.

Durable Medical Equipment (DME) providers, Orthotic providers and Prosthetic providers are participating providers. Please refer to your Policy Book for details.

* *Does not apply to out-of-pocket expense limit.*

** *In order to receive benefits for Substance Abuse care (other than alcoholism), the treatment program must be approved by Blue Cross and Blue Shield of Illinois. Contact the Mental Health Unit for additional details.*

† *Deductible does not apply.*

IF USING A NON-PLAN PROVIDER... A $300 per Hospital admission Deductible will apply.* If using a Non-Plan Provider, benefits are reduced to 50%. However, with the exception of alcoholism, no benefits are available for Substance Abuse Rehabilitation Treatment. Also, Outpatient Hospital and Physician emergency care, and additional surgical opinions are paid at 100%, regardless of the coverage level or Provider selected.

PRE-EXISTING CONDITIONS LIMITATION Pre-existing Conditions are those health conditions which were diagnosed or treated by a Provider during the 12 months prior to the coverage effective date, or for which symptoms existed which would cause an ordinarily prudent person to seek diagnosis or treatment. Any Pre-existing Condition will be subject to a waiting period of 365 days. This limitation does not apply to individuals under 19 years of age.

PREMIUMS We may change premium rates only if we do so on a class basis for all DB-42 HCSC policies. Premiums can be changed based on age, sex, and rating area.

GUARANTEED RENEWABILITY Coverage under this Policy will be terminated for nonpayment of premiums. In addition, Blue Cross and Blue Shield may terminate or refuse to renew this Policy only for the following reasons:

1. If every Policy that bears this Policy form number, DB-42 HCSC, is not renewed. If this should occur:
   a. Blue Cross and Blue Shield will give you at least 90 days prior to written notice.
   b. You may convert to any other individual policy Blue Cross and Blue Shield offers to the individual market.
2. In the event of an act, practice or omission that constitutes fraud or making an intentional misrepresentation of material fact on your application may result in rescission of coverage. Rescission is defined as a cancellation or discontinuance of coverage that has a retroactive effect. You will be provided with at least 30 days' advance written notice before you or your dependent's coverage may be rescinded, retroactive to the effective date of coverage.
3. If you no longer reside, live or work in an area for which Blue Cross and Blue Shield is authorized to do business. Blue Cross and Blue Shield will never terminate or refuse to renew this Policy because of the condition of your health. Blue Cross and Blue Shield may uniformly modify coverage provided by every Policy which bears this Policy form number only on the coverage Renewal Date.

Exclusions and Limitations:

Hospitalization, Services, and supplies which are not Medically Necessary; 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; Services or supplies that are furnished to you by the local, state, or federal government; 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 or dental practice; Investigational Services and Supplies, including all related services and supplies; Custodial Care Service; Routine physical examinations, unless specifically stated in this Policy; Services or supplies received during an Inpatient stay when the stay is primarily related to behavioral, social maladjustment, lack of discipline, or other antisocial actions which are not specifically the result of Mental Illness; Cosmetic Surgery and related services and supplies, except for the correction of congenital deformities or for conditions resulting from accidental injuries, scars, tumors, or diseases; Services or supplies for which you are not required to make payment or would have no legal obligation to pay if you did not have this or similar coverage; Charges for failure to keep a scheduled visit or charges for completion of a Claim form; Personal hygiene, comfort, or convenience items commonly used for other than medical purposes, such as air conditioners, humidifiers, physical fitness equipment, televisions, and telephones; Special braces, splints, specialized equipment, appliances, ambulatory apparatus, battery controlled implants, except as specifically mentioned in this Policy; 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; 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; Immunizations, unless otherwise stated in this Policy; Maintenance Occupational Therapy, Maintenance Physical Therapy, and Maintenance Speech Therapy; Speech Therapy when rendered for the treatment of psychosocial speech delay, behavioral problems (including impulsive behavior and impulsivity syndrome), attention disorder, conceptual handicap, or mental retardation; Hearing aids or examinations for the prescription or fitting of hearing aids; Diagnostic Service as part of routine physical examinations or check-ups, premarital examinations, determination of the refractive errors of the eyes, auditory problems, surveys, casefinding, research studies, screening, or similar procedures and studies, or tests which are Investigational, unless otherwise specified in this Policy; Procurement or use of prosthetic devices, special appliances, and surgical implants which are for cosmetic purposes, or unrelated to the treatment of a disease or injury; Services and supplies provided for the diagnosis and/or treatment of infertility including, but not limited to, Hospital services, Medical Care, therapeutic injection, fertility and other drugs, Surgery, artificial insemination, and all forms of in-vitro fertilization; Maternity Service, including related services and supplies, unless selected as an option (Complications of Pregnancy are covered as any other illness).

* *Does not apply to out-of-pocket expense limit.*

BlueCross BlueShield of Illinois

Experience. Wellness. Everywhere.®

SelectBlue Advantage℠

With your choice of deductibles.

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. SelectBlue Advantage Coverage — SelectBlue Advantage 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 SelectBlue Advantage plan will be greater when you use the services of participating Hospitals and Physicians.**

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

BASIC PROVISIONS	SELECTBLUE ADVANTAGE	
	Participating Provider Coverage	Non-Participating Provider Coverage
Deductible Per individual, per calendar year. (If two or more family members receive covered services as a result of injuries received in the same accident, only one Deductible will apply.) *Carryover Deductible* If an insured incurs covered expenses for the Deductible in the last three months of the calendar year, we will carry over that amount as credit toward the Deductible for the following calendar year.	$250★ $500★ $1,000★ $1,750★ $2,500★ $5,000★	
Family Aggregate Deductible Per family, per calendar year.	Equal to three times the individual Deductible	
Hospital Admission Deductible Per admission, per individual.	$0	$300★
Coinsurance The level of coverage provided by the plan after the calendar year Deductible has been satisfied.	80%	50%
Out-of-Pocket Expense Limit The amount of money an individual pays toward covered hospital and medical expenses during any one calendar year. Items asterisked (★) do not apply to the out-of-pocket expense limit.	$3,000	$6,000
Family Aggregate Out-of-Pocket Expense Limit Equal to three times the individual out-of-pocket limit, per family, per calendar year.	$9,000	$18,000

BASIC PROVISIONS	SELECTBLUE ADVANTAGE	
	Participating Provider Coverage	Non-Participating Provider Coverage
Outpatient Physician Medical/Surgical Services Covered services OTHER THAN surgery, therapy, and certain diagnostic services received in a provider's office, which are described immediately below	100% after you pay $30 copayment per visit★†	50%
Surgery, therapy, and certain diagnostic services including MRI, CT scan, pulmonary function studies, cardiac catheterization, EEG, EKG, ECG, and Swan-Ganz catheterization.	80%	50%
Inpatient Physician Medical/Surgical Services	80%	50%
Preventive Care Services Benefits will be provided for the following Covered Services and will not be subject to Coinsurance, deductible, Copayment or maximum when in-network providers are used: a. 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"); b. immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention ("CDC") with respect to the individual involved; c. 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 d. with respect to women, such additional preventive care and screenings, not described in item a above, as 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).	100%†	50%
Inpatient/Outpatient Hospital Services Includes surgery, pre-admission testing and services received in a skilled nursing facility, coordinated home care program and hospice. (For mental health coverage levels, please refer to mental health benefits on the next page.)	80%	50%
Inpatient/Outpatient Hospital Diagnostic Testing Includes, but not limited to, X-rays, lab tests, EKGs, ECGs, pathology services, pulmonary function studies, radioisotope tests, and electromyograms	80%	50%
Physical, Occupational, and Speech Therapist Services (70 visits per calendar year for physical therapy; 45 visits per calendar year for occupational therapy; 30 visits per calendar year for speech therapy.)	80%★	50%★
Temporomandibular Joint Dysfunction and Related Disorders	80%★	50%★
Optional Maternity Coverage Inpatient/Outpatient Hospital services and Physician Medical/Surgical services. *When elected, maternity benefits will begin 365 days after the effective date of the maternity coverage.*	80%	50%
Outpatient Emergency Care (Accident or Illness) For both Hospital and Physician.	80% after you pay $75 copayment†	
Additional Surgical Opinion Program Following a recommendation for elective surgery, provides additional consultations and related diagnostic service by a Physician, as needed.	100%†	

BASIC PROVISIONS	SELECTBLUE ADVANTAGE	
	Participating Provider Coverage	Non-Participating Provider Coverage
Other Covered Services Ambulance services; services of a private duty nursing service (4 visits per month); naprapathic services rendered by a Naprapath ($1,000 per calendar year maximum★); oxygen and its administration; blood plasma; surgical dressings; casts and splints.	80%	
Mental Illness Treatment and Substance Abuse Rehabilitation Treatment		
Inpatient Care (30 Inpatient Hospital days per calendar year.)		
Physician	80%★	50%★
Hospital First 14 days	60%★	50%★
Thereafter	50%★	50%★
Outpatient Care (30 visits per calendar year combined annual maximum and 100 visits per lifetime maximum.)		
Physician and Hospital	50%★	50%★
Medical Services Advisory (MSA®) In order to maximize your benefits, the Policyholder is responsible for notifying the MSA for Hospital admissions at Non-Participating and Non-Plan Hospitals. (MSA notification by the Policyholder is NOT required when services are rendered in a Participating Hospital.) MSA notification is required within three business days for non-emergencies and within one business day or as soon as reasonably possible for emergencies and maternity admissions. Failure to contact the MSA will result in a reduction of Hospital benefits of $1,000.★		
Mental Health Unit In order to maximize your benefits, the Policyholder is responsible for notifying the Mental Health Unit for ALL care related to mental health and substance abuse. In the event of an admission, for either mental illness or substance abuse, notification is required three days prior for non-emergencies and within 24 hours or as soon as reasonably possible for emergencies. Failure to contact the Mental Health Unit may result in a reduction of benefits of up to $1,000.★		

OUTPATIENT PRESCRIPTION DRUG BENEFIT	YOU PAY	SELECTBLUE ADVANTAGE PAYS
	Participating Pharmacy††	Participating Pharmacy††
$250 and $500 Deductible plans ONLY		
• Generic	$10 copayment★	100%
• Brand formulary & Insulin and Insulin syringes	35%★	65%
• Brand non-formulary	50%★	50%
($100 out-of-pocket maximum per prescription.)		
Home Delivery: Up to a 90-day supply of maintenance drugs is available through home delivery and is subject to $300 out-of-pocket maximum per prescription.		
• Generic	$20 copayment★	100%
• Brand formulary & Insulin and Insulin syringes	35%★	65%
• Brand non-formulary	50%★	50%
$1,000, $1,750, $2,500, and $5,000 Deductible plans ONLY (Subject to deductible and coinsurance.)	20%	80%

Benefits for covered services are provided at either the Eligible Charge or the Maximum Allowance. Consult the Policy for definitions and your financial responsibility.

Durable Medical Equipment (DME) providers, Orthotic providers and Prosthetic providers are participating providers. Please refer to your Policy Book for details.

★ *Does not apply to out-of-pocket expense limit.*
† *Deductible does not apply.*
†† *Benefits will be significantly reduced if you use a non-participating pharmacy.*

IF USING A NON-PLAN PROVIDER... A $300 per Hospital admission Deductible will apply.* If using a Non-Plan Provider, benefits are reduced to 50%. However, Outpatient Hospital emergency care is paid at 80% after you pay a $75 copayment, regardless of your coverage level or whether services were received from a Participating, Non-Participating or Non-Plan Provider.

PRE-EXISTING CONDITIONS LIMITATION Pre-existing Conditions are those health conditions which were diagnosed or treated by a Provider during the 12 months prior to the coverage effective date, or for which symptoms existed which would cause an ordinarily prudent person to seek diagnosis or treatment. Any Pre-existing Condition will be subject to a waiting period of 365 days. This limitation does not apply to individuals under 19 years of age.

PREMIUMS We may change premium rates only if we do so on a class basis for all DB-48 HCSC policies. Premiums can be changed based on age, sex, and rating area.

GUARANTEED RENEWABILITY Coverage under this Policy will be terminated for nonpayment of premiums. In addition, Blue Cross and Blue Shield may terminate or refuse to renew this Policy only for the following reasons:

1. If every Policy that bears this Policy form number, DB-48 HCSC, is not renewed. If this should occur:
   a. Blue Cross and Blue Shield will give you at least 90 days prior to written notice.
   b. You may convert to any other individual policy Blue Cross and Blue Shield offers to the individual market.
2. In the event of an act, practice or omission that constitutes fraud or making an intentional misrepresentation of material fact on your application may result in rescission of coverage. Rescission is defined as a cancellation or discontinuance of coverage that has a retroactive effect. You will be provided with at least 30 days' advance written notice before you or your dependent's coverage may be rescinded, retroactive to the effective date of coverage.
3. If you no longer reside, live or work in an area for which Blue Cross and Blue Shield is authorized to do business. Blue Cross and Blue Shield will never terminate or refuse to renew this Policy because of the condition of your health. Blue Cross and Blue Shield may uniformly modify coverage provided by every Policy which bears this Policy form number only on the coverage Renewal Date.

Exclusions and Limitations:

Hospitalization, Services, and supplies which are not Medically Necessary; 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 except where not required by law; Services or supplies that are furnished to you by the local, state, or federal government; 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 or dental practice; Investigational Services and Supplies, including all related services and supplies; Custodial Care Service; Routine physical examinations, unless specifically stated in this Policy; Services or supplies received during an Inpatient stay when the stay is primarily related to behavioral, social maladjustment, lack of discipline, or other antisocial actions which are not specifically the result of Mental Illness; Cosmetic Surgery and related services and supplies, except for the correction of congenital deformities or for conditions resulting from accidental injuries, scars, tumors, or diseases; Services or supplies for which you are not required to make payment or would have no legal obligation to pay if you did not have this or similar coverage; Charges for failure to keep a scheduled visit or charges for completion of a Claim form; Personal hygiene, comfort, or convenience items commonly used for other than medical purposes, such as air conditioners, humidifiers, physical fitness equipment, televisions, and telephones; Special braces, splints, specialized equipment, appliances, ambulatory apparatus, battery controlled implants, except as specifically mentioned in this Policy; 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; 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; Immunizations, unless otherwise stated in this Policy; Maintenance Occupational Therapy, Maintenance Physical Therapy, and Maintenance Speech Therapy; Speech Therapy when rendered for the treatment of psychosocial speech delay, behavioral problems (including impulsive behavior and impulsivity syndrome), attention disorder, conceptual handicap, or mental retardation; Hearing aids or examinations for the prescription or fitting of hearing aids; Diagnostic Service as part of routine physical examinations or check-ups, premarital examinations, determination of the refractive errors of the eyes, auditory problems, surveys, casefinding, research studies, screening, or similar procedures and studies, or tests which are Investigational, unless otherwise specified in this Policy; Procurement or use of prosthetic devices, special appliances, and surgical implants which are for cosmetic purposes, or unrelated to the treatment of a disease or injury; Services and supplies provided for the diagnosis and/or treatment of infertility including, but not limited to, Hospital services, Medical Care, therapeutic injection, fertility and other drugs, Surgery, artificial insemination, and all forms of in-vitro fertilization; Maternity Service, including related services and supplies, unless selected as an option (Complications of Pregnancy are covered as any other illness). Long Term Care; Inpatient Private Duty Nursing Service; Maintenance Care; Wigs (also referred to as cranial prosthesis); and Services and supplies rendered or provided for human organ or tissue transplants other than those specifically named in this Policy.

* *Does not apply to out-of-pocket expense limit.*