



BlueCross BlueShield  
of Illinois

MAJOR MEDICAL PLANS  
AT AFFORDABLE RATES

BlueChoice<sup>®</sup>  
& Select  
BlueChoice<sup>®</sup>  
Value

BlueChoice<sup>®</sup> Network Plans

Now Available to Children  
on an Individual Basis!

INDIVIDUAL AND FAMILY HEALTH INSURANCE

it just fits.

HEALTH INSURANCE FOR INDIVIDUAL ADULTS, CHILDREN  
BLUE CROSS AND BLUE SHIELD OF ILLINOIS

It fits your life...

## BlueChoice Select

If you want broad major medical benefits and savings of the BlueChoice network,<sup>1</sup> it just fits

Try this on for size...a healthcare plan where a \$30 copayment covers doctor office visits, well-child care and more...a plan that lets you select from a wide range of deductibles, to make it easy to tailor a plan to your needs and budget...a plan that lets you present a drug card to have your generic prescriptions filled for a \$10 copayment. Sound like a good fit so far? How about a plan that does all this and helps you stay healthy by covering preventive care with a well-adult care benefit?



Blue Cross and Blue Shield of Illinois brings you a plan that fits your expectations by giving you the benefits you deserve...at a price that's much lower than what you might expect for a major medical plan. It's called BlueChoice Select, and it offers individual adults, individual children and families a broad range of benefits *and savings*. Through an agreement with providers in your area who participate in the BlueChoice network, BlueChoice Select can help you save on the cost of your coverage and the cost of covered services. In fact, with BlueChoice Select, you can save as much as 19% over our comparable major medical plan that does not use the BlueChoice contracting provider network!

<sup>1</sup>BlueChoice provides you with access to contracting providers.

& FAMILIES FROM

and your budget!

## BlueChoice Value

A smart choice for reliable health insurance coverage at rates to fit your budget

If you're looking for reliable benefits at a lower premium, consider our BlueChoice Value plan. Like BlueChoice Select, it offers the money-saving advantages of the BlueChoice network and gives you the benefits you deserve — including coverage for hospitalization, doctor office visits, emergency care, outpatient prescription drugs, well-child care and optional maternity care.

Because BlueChoice Value leaves out features such as a doctor office visit copayment and a prescription drug copayment feature, you can enjoy a lower monthly premium. If you're looking for a great combination of benefits at a price that fits your budget, choose BlueChoice Value!

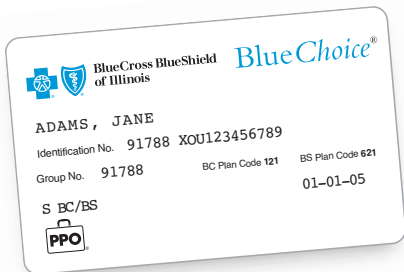


**BlueCross BlueShield  
of Illinois**



# BlueChoice Select & BlueChoice Value

THE MAJOR MEDICAL BENEFITS YOU DESERVE  
AT SURPRISINGLY AFFORDABLE RATES



Both BlueChoice Select and BlueChoice Value provide reliable benefits for doctor office visits, outpatient services, emergency care, prescription drugs, well-child care and more. Plus, both of these health insurance plans help you save money on premiums and the cost of covered services through the BlueChoice contracting provider network. Whether it's coverage for yourself, your children or your whole family, you'll have the reassurance in knowing your health care plan is backed by a company that has served Illinois residents for over 65 years:

*Blue Cross and Blue Shield of Illinois.*

## **\$30 Office Visit Copayment with BlueChoice Select**

With BlueChoice Select, you pay a \$30 office visit copayment when you use contracting providers. You simply pay your doctor \$30 at the time of your visit and your copayment covers that office visit, as well as those covered services that are billed by your physician on the same day. Well-child care is also \$30 per visit with BlueChoice Select.

## **BlueChoice Select features preventive care coverage!**

The well-adult care benefit offers as much as \$500 in benefits annually and covers an annual physical exam and an annual gynecological exam. It also includes immunizations and certain routine diagnostic tests. You pay a \$30 office visit copayment when you use contracting providers!

## **A Choice of Deductibles Helps You Tailor a Plan to Your Budget**

Both BlueChoice Select and BlueChoice Value offer a choice of a \$250, \$500, \$1,000, \$1,750, \$2,500 or \$5,000 deductible. Whatever your budget, we have an option for you.

## **80% Coverage for Most Services**

The coverage level (percentage) that BlueChoice Select and BlueChoice Value pay for covered services after you meet your deductible is called coinsurance. With 80% coinsurance, you pay 20% of your eligible bills until you've paid \$3,000 (after you've met your deductible, and when you use contracting providers). At that point, both BlueChoice Select and BlueChoice Value go on to pay 100% of these services for the remainder of the calendar year.

## **The Security of \$5,000,000 in Lifetime Protection for Yourself, Your Children or Your Whole Family**

With BlueChoice Select and BlueChoice Value, individual adults, individual children and families may apply for coverage. Family coverage protects you, your spouse and your eligible dependent children under age 19 (age 25 if a single, full-time student). Each person will be eligible for \$5,000,000 in lifetime benefits. That's substantial protection for today and the years ahead.

## **Prescription Drug Coverage, Including Generic Prescriptions for a \$10 Copayment with BlueChoice Select**

With both plans, you get coverage for outpatient prescription medications.

## **When you choose a \$250 or \$500 deductible with BlueChoice Select:**

Simply present your prescription drug card at participating pharmacies and pay a \$10 copayment for generic prescriptions. Pay 35% for name-brand formulary drugs, insulin and insulin syringes and 50% for name-brand non-formulary medications. You can even take advantage of a program that offers convenient home delivery for maintenance drugs.

## **When you choose a \$1,000, \$1,750, \$2,500 or \$5,000 deductible with BlueChoice Select or any deductible with BlueChoice Value:**

Outpatient prescription drugs are covered at 80% after you've met your deductible. Your claim will be automatically processed when you purchase your prescription drugs at any one of the participating pharmacies in Illinois — that's 98% of Illinois pharmacies!

## The BlueChoice Network Saves You Money!

Our BlueChoice Select and BlueChoice Value health insurance plans give you access to the BlueChoice network of contracting providers, including hospitals, physicians and specialists close to your home. Our agreements with these contracting providers allow you to save on premiums — as much as 19% over our comparable major medical plans! But that's not all. You'll also save on the cost of covered services when you use these contracting providers.

Your benefits are paid at the highest level when you receive care from a BlueChoice network contracting provider. You do not need to select a primary care physician to coordinate care and you don't need a referral to see a specialist. You can receive care from a provider outside the network, but your benefits will be paid at a lower level and your out-of-pocket cost will be significantly higher.

The BlueChoice hospital network was created based on geographic accessibility, the number of board-certified physicians on staff and status with the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). Count on BlueChoice Select and BlueChoice Value to give you savings, a broad range of benefits and the flexibility you want in making your care choices.

To view a listing of BlueChoice network doctors, specialists and hospitals, visit [www.bcbsil.com](http://www.bcbsil.com).

## 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. This is a nationwide network of participating providers that allows 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 BlueCard PPO provider wherever you are.

## No Paperwork — Your Claims Are Handled for You

In most cases, all you have to do is show your Blue Cross and Blue Shield ID card at a doctor's office or hospital, and your claim will be filed for you.

## Guaranteed Renewability

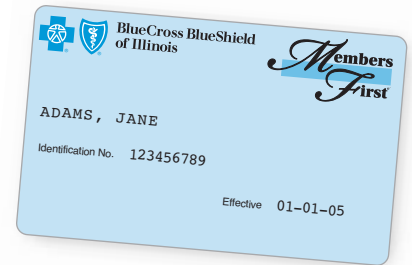
As long as your premiums are paid on time, your coverage can be non-renewed only for the following reasons: (1) fraud or an intentional material misrepresentation, or (2) all policies bearing your policy's form number are non-renewed.

## Financial Stability You Can Count On

Today one American in three carries a Blue Cross and Blue Shield membership card. In fact, over four million residents across Illinois *Carry the Caring Card*<sup>®</sup>. Blue Cross and Blue Shield of Illinois has been serving the health insurance needs of Illinois residents for more than 65 years. We're one of the largest and most financially secure insurance companies in the state. A.M. Best, one of the leading rating agencies of the insurance industry, has awarded us an "A" (Excellent) rating.\*

## Members First<sup>®</sup> — Substantial Savings on Dental, Vision and Hearing Care Products and Services...

Members First<sup>®</sup> is a money-saving discount program that automatically comes with BlueChoice Select and BlueChoice Value. You and your covered family members will also receive Members First identification cards for on-the-spot savings on a variety of products and services. Because this isn't insurance, there are no deductibles, no dollar maximum limits, and no claim forms to fill out. Using this program costs you nothing extra. It's just our way of saying "thank you" for being a member.



## Save as much as 50% on vision care

Save on eyeglasses and contact lenses at more than 9,000 participating locations nationwide, including LensCrafters, Sears, JCPenney and Pearle Vision. You'll also be entitled to discounts on eye examinations and surgical procedures, including Lasik surgery where available.

## Save as much as 50% on dental care

Save on routine and extensive dental care treatments (such as root canals, crowns and dentures) at more than 15,000 participating providers located all across the country.

## Save as much as 20% on hearing care services

Save on hearing aids, and get discounts on consultations and hearing aid evaluations from the largest network of audiologists in the U.S.

## Save as much as 40% on chiropractic care

Save at over 350 participating chiropractors across Illinois — with unlimited visits for care.

## Save on vitamins and nutritional supplements through mail order

Choose from a variety of vitamins and nutritional supplements and save 25% to 50% on already-low mail-order catalog prices.

\* As of June 2004



WHATEVER YOUR NEEDS AND BUDGET,

# Blue Cross and Blue Shield of Illinois

COVERAGE AVAILABLE TO INDIVIDUAL ADULTS, INDIVIDUAL CHILDREN

BENEFIT	BlueChoice Select	BlueChoice Value
	In-Network Provider Coverage <sup>1</sup>	In-Network Provider Coverage <sup>1</sup>
<b>Provider Network</b>	BlueChoice Provider Network	
<b>Lifetime Benefit</b>	\$5,000,000	
<b>Individual Deductible</b>	\$250, \$500, \$1,000, \$1,750 \$2,500 or \$5,000 <sup>2</sup>	
<b>Individual Out-of-Pocket Expense Limit</b>	\$3,000	
<b>Office Visits and Outpatient Physician Services</b>	100% after you pay \$30 copayment per visit <sup>2,3</sup> (Deductible does not apply)	80%
<b>Hospital Services</b>		
<ul style="list-style-type: none"> <li>• <b>Inpatient Physician Services</b></li> </ul>	80%	
<ul style="list-style-type: none"> <li>• <b>Outpatient Services</b> Includes surgery and pre-admission testing</li> </ul>	80%	
<ul style="list-style-type: none"> <li>• <b>Inpatient Services</b> Includes semi-private room and board, pre-admission testing, prescription drugs and more</li> </ul>	80%	
<ul style="list-style-type: none"> <li>• <b>Inpatient/Outpatient Diagnostic Testing</b> Includes X-rays, lab tests, EKGs, ECGs, pathology services, pulmonary function studies and more</li> </ul>	80%	
<b>Well-Adult Care</b> From age 16. Covers services associated with both an annual physical exam and an annual gynecological exam. Includes immunizations and routine diagnostic tests received or ordered on the same day as part of the exam. (\$500 calendar year maximum per person)	100% after you pay \$30 copayment per visit <sup>2</sup> (Deductible does not apply)	Not covered
<b>Well-Child Care</b> To age 16. Includes immunizations, physical exams and routine diagnostic tests. (\$500 per calendar year maximum)	100% after you pay \$30 copayment per visit <sup>2</sup> (Deductible does not apply)	80%
<b>Outpatient Emergency Care</b> Includes covered services received in a hospital or a physician's office	80% after \$75 copayment per visit (Deductible does not apply)	
<b>Physical, Occupational, or Speech Therapist</b> (\$3,000 per therapy, per calendar year maximum)	80% <sup>2</sup>	

# Has a Plan That Fits!

## AND FAMILIES

BENEFIT	BlueChoice Select	BlueChoice Value
	In-Network Provider Coverage <sup>1</sup>	In-Network Provider Coverage <sup>1</sup>
<b>Outpatient Prescription Drugs</b>	<b>\$250 and \$500 Deductible plans ONLY</b> <ul style="list-style-type: none"> <li>• Generic . . . . .100% (after \$10 copayment)</li> <li>• Brand formulary . . . . .65%<sup>2</sup></li> <li>• Brand non-formulary . . . .50%<sup>2</sup></li> </ul> Home delivery: Up to a 90-day supply of maintenance drugs is available through home delivery and is subject to a \$300 maximum per prescription	80%
<b>Mental Illness Treatment and Substance Abuse Rehabilitation Treatment<sup>4</sup></b>		
<b>Inpatient Care</b> (30 Inpatient Hospital days per calendar year)		
<ul style="list-style-type: none"> <li>• Physician</li> </ul>		80% <sup>2</sup>
<ul style="list-style-type: none"> <li>• Hospital — First 14 days</li> </ul>		60% <sup>2</sup>
Thereafter		50% <sup>2</sup>
<b>Outpatient Care</b> (30 visits per calendar year combined annual maximum and 100 visits per lifetime maximum)		
<ul style="list-style-type: none"> <li>• Physician and Hospital</li> </ul>		50% <sup>2</sup>
<b>Optional Maternity Coverage</b> Inpatient/Outpatient Hospital Services and Physician Medical/Surgical Services <i>When elected, maternity benefits will begin 365 days after the effective date of the maternity coverage</i>		80%

<sup>1</sup> Benefits are reduced when out-of-network providers are used.

<sup>2</sup> Does not apply to out-of-pocket expense limit.

<sup>3</sup> Services not billed as part of the office visit by your physician on the same day are subject to your deductible and coinsurance. These might include, but are not limited to outpatient lab tests. Outpatient surgery, therapy and certain diagnostic services (including MRI, CT scan, pulmonary function studies, cardiac catheterization, EEG, EKG, ECG and swan ganz catheterization) are not covered by the copayment and instead are covered subject to the plan's deductible and coinsurance.

<sup>4</sup> 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.

### Maximizing Your Benefits Can Be Just a Phone Call Away!

Blue Cross and Blue Shield of Illinois wants to make sure you get the maximum coverage and the most appropriate care. That's why our health insurance plans include the services of two units of health professionals. They're called the Mental Health Unit and the Medical Services Advisory (MSA®). By calling one of these units whenever you need mental health and substance abuse services, or if you find yourself receiving treatment at an out-of-network hospital, you're assured of maximum benefits and the very best health care.



# BlueChoice® 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 **READYOUR POLICY CAREFULLY!**
- 2. BlueChoice Select Coverage** — BlueChoice 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 BlueChoice Select plan will be greater when you use the services of designated Hospitals and Physicians.**

BASIC PROVISIONS	BLUECHOICE SELECT	
	In-Network Provider Coverage	Out-of-Network Provider Coverage
<b>Lifetime Benefit</b>	\$5,000,000	
<p><b>Deductible</b> 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.)</p> <p><i>Carryover Deductible</i> 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.</p>	<p>\$250*</p> <p>\$500*</p> <p>\$1,000*</p> <p>\$1,750*</p> <p>\$2,500*</p> <p>\$5,000*</p>	<p>\$750*</p> <p>\$1,500*</p> <p>\$3,000*</p> <p>\$5,250*</p> <p>\$7,500*</p> <p>\$15,000*</p>
<b>Family Aggregate Deductible</b> Per family, per calendar year.	Equal to two times the individual Deductible	
<b>Hospital Admission Deductible</b> Per admission, per individual.	\$0	\$300*
<b>Coinsurance</b> The level of coverage provided by the plan after the calendar year Deductible has been satisfied.	80%	50%
<b>Out-of-Pocket Expense Limit</b> The amount of money an individual pays toward covered hospital and medical expenses during any one calendar year. Items asterisked (*) <u>do not</u> apply to the out-of-pocket expense limit.	\$3,000	\$6,000
<b>Family Aggregate Out-of-Pocket Expense Limit</b> Equal to two times the individual out-of-pocket limit, per family, per calendar year.	\$6,000	\$12,000

BASIC PROVISIONS	BLUECHOICE SELECT	
	In-Network Provider Coverage	Out-of-Network Provider Coverage
<p><b>Outpatient Physician Medical/Surgical Services</b> Covered services OTHER THAN surgery, therapy, and certain diagnostic services received in a provider's office, which are described immediately below</p> <p><i>Surgery, therapy, and certain diagnostic services including MRI, CT scan, pulmonary function studies, cardiac catheterization, EEG, EKG, ECG, and swan ganz catheterization.</i></p>	100% after you pay \$30 copayment per visit*†	50%
<p><b>Inpatient Physician Medical/Surgical Services</b></p>	80%	50%
<p><b>Wellness Care</b> From age 16. Covers services associated with both an annual physical exam and an annual gynecological exam. Includes immunizations and routine diagnostic tests received or ordered on the same day as part of the exam. (\$500 calendar year maximum per person.)</p> <p><i>When covered services are received in a provider's office</i></p> <p><i>When covered services are received OTHER THAN in a provider's office</i></p>	<p>100% after you pay \$30 copayment per visit*†</p> <hr style="border-top: 1px dashed black;"/> <p>100%†</p>	50%*
<p><b>Well-Child Care</b> To age 16. Includes immunizations, physical exams and routine diagnostic tests. (\$500 calendar year maximum, per dependent for non-participating provider services only.)</p>	100% after you pay \$30 copayment per visit†	50%*
<p><b>Inpatient/Outpatient Hospital Services</b> 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.)</p>	80%	50%
<p><b>Inpatient/Outpatient Hospital Diagnostic Testing</b> Includes, but not limited to, X-rays, lab tests, EKGs, ECGs, pathology services, preliminary function studies, radioisotope tests, and electromyograms</p>	80%	50%
<p><b>Physical, Occupational, and Speech Therapist Services</b> (\$3,000 maximum per therapy, per calendar year.)</p>	80%*	50%*
<p><b>Temporomandibular Joint Dysfunction and Related Disorders</b> (\$1,000 lifetime maximum.)</p>	80%*	50%*
<p><b>Optional Maternity Coverage</b> Inpatient/Outpatient Hospital services and Physician Medical/Surgical services. <i>When elected, maternity benefits will begin 365 days after the effective date of the maternity coverage.</i></p>	80%	50%
<p><b>Outpatient Emergency Care (Accident or Illness)</b> For both Hospital and Physician.</p>	80% after you pay \$75 copayment†	
<p><b>Additional Surgical Opinion Program</b> Following a recommendation for elective surgery, provides additional consultations and related diagnostic service by a Physician, as needed.</p>	100%†	100%†

BASIC PROVISIONS	BLUECHOICE SELECT	
	In-Network Provider Coverage	Out-of-Network Provider Coverage
<p><b>Other Covered Services</b> Ambulance services; durable medical equipment; services of a private duty nursing service (\$1,000 per month maximum*); naprapathic services rendered by a Naprapath (\$1,000 per calendar year maximum*); artificial limbs and other prosthetic devices; oxygen and its administration; blood plasma; leg, arm and neck braces; surgical dressings; casts and splints.</p>	80%	
<p><b>Mental Illness Treatment and Substance Abuse Rehabilitation Treatment</b></p> <p><b>Inpatient Care</b> (30 Inpatient Hospital days per calendar year.)</p> <p>Physician</p> <p>Hospital First 14 days Thereafter</p> <p><b>Outpatient Care</b> (30 visits per calendar year combined annual maximum and 100 visits per lifetime maximum.)</p> <p>Physician and Hospital</p>	80%* 60%* 50%* 50%*	50%* 50%* 50%*
<p><b>Medical Services Advisory (MSA®)</b> 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.*</p>		
<p><b>Mental Health Unit</b> 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.*</p>		

OUTPATIENT PRESCRIPTION DRUG BENEFIT	YOU PAY	BLUECHOICE SELECT PAYS
	Participating Pharmacy††	Participating Pharmacy††
<p><b>\$250 and \$500 Deductible plans ONLY</b></p> <ul style="list-style-type: none"> <li>• Generic</li> <li>• Brand formulary &amp; Insulin and Insulin syringes</li> <li>• Brand non-formulary</li> </ul> <p>(\$100 out-of-pocket maximum per prescription.)</p> <p><i>Home Delivery:</i> Up to a 90-day supply of maintenance drugs is available through home delivery and is subject to \$300 maximum per prescription.</p> <ul style="list-style-type: none"> <li>• Generic</li> <li>• Brand formulary &amp; Insulin and Insulin syringes</li> <li>• Brand non-formulary</li> </ul>	<p>\$10 copayment*</p> <p>35%*</p> <p>50%*</p>	<p>100%</p> <p>65%</p> <p>50%</p>
<p><b>\$1,000, \$1,750, \$2,500, and \$5,000 Deductible plans ONLY</b> (Subject to deductible and coinsurance.)</p>	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.

\* 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.

**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 non-payment of premium. Blue Cross and Blue Shield can refuse to renew this Policy only for the following reasons:

- A. If all Policies bearing form number DB-46 HCSC are not renewed, written notice will be provided at least 90 days before coverage is discontinued. Furthermore, you may convert to any other individual policy Blue Cross and Blue Shield offers to the individual market.
- B. In the event of fraud or an intentional misrepresentation of material fact under the terms of the coverage, written notice will be given at least 30 days before coverage is discontinued.

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### 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.

A Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association

#### CONSUMER MARKETS

® Registered Service Marks of the Blue Cross and Blue Shield Association, an Association of Independent Blue Cross and Blue Shield Plans

® Registered Service Mark of Health Care Service Corporation



# BlueChoice® 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. **BlueChoice Value Coverage** — BlueChoice 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 BlueChoice Value plan will be greater when you use the services of designated Hospitals and Physicians.**

BASIC PROVISIONS	BLUECHOICE VALUE	
	In-Network Provider Coverage	Out-of-Network Provider Coverage
<b>Lifetime Benefit</b>	\$5,000,000	
<b>Deductible</b> 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.)  <i>Carryover Deductible</i> 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*
<b>Family Aggregate Deductible</b> Per family, per calendar year.	Equal to two times the individual Deductible	
<b>Hospital Admission Deductible</b> Per admission, per individual.	\$0	\$300*
<b>Coinsurance</b> The level of coverage provided by the plan after the calendar year Deductible has been satisfied.	80%	50%
<b>Out-of-Pocket Expense Limit</b> The amount of money an individual pays toward covered hospital and medical expenses during any one calendar year. Items asterisked (*) <u>do not</u> apply to the out-of-pocket expense limit.	\$3,000	\$6,000
<b>Family Aggregate Out-of-Pocket Expense Limit</b> Equal to two times the individual out-of-pocket limit, per family, per calendar year.	\$6,000	\$12,000

BASIC PROVISION	BLUECHOICE VALUE	
	In-Network Provider Coverage	Out-of-Network Provider Coverage
<b>Inpatient/Outpatient Physician Medical/Surgical Services</b>	80%	50%
<b>Well-Child Care</b> To age 16. Includes immunizations, physical exams, and routine diagnostic tests. (\$500 per calendar year maximum, per dependent.)	80%	50%*
<b>Inpatient/Outpatient Hospital Services</b> 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%
<b>Inpatient/Outpatient Hospital Diagnostic Testing</b> Includes, but not limited to, X-rays, lab tests, EKGs, ECGs, pathology services, pulmonary function studies, radioisotope tests, and electromyograms.	80%	50%
<b>Physical, Occupational, and Speech Therapist Services</b> (\$3,000 maximum per therapy, per calendar year.)	80%*	50%*
<b>Temporomandibular Joint Dysfunction and Related Disorders</b> (\$1,000 lifetime maximum.)	80%*	50%*
<b>Optional Maternity Coverage</b> Inpatient/Outpatient Hospital services and Physician Medical/Surgical services. <i>When elected, maternity benefits will begin 365 days after the effective date of the maternity coverage.</i>	80%	50%
<b>Outpatient Emergency Care (Accident or Illness)</b> For both Hospital and Physician.	80% after you pay \$75 copayment†	
<b>Additional Surgical Opinion Program</b> Following a recommendation for elective surgery, provides additional consultations and related diagnostic service by a Physician, as needed.	100%†	
<b>Other Covered Services</b> Ambulance services; durable medical equipment; services of a private duty nursing service (\$1,000 per month maximum*); naprapathic services rendered by a Naprapath (\$1,000 per calendar year maximum*); artificial limbs and other prosthetic devices; oxygen and its administration; blood plasma; leg, arm and neck braces; surgical dressings; casts and splints; and outpatient prescription drugs.	80%	

BASIC PROVISIONS	BLUECHOICE VALUE	
	In-Network Provider Coverage	Out-of-Network Provider Coverage
<p><b>Mental Illness Treatment and Substance Abuse Rehabilitation Treatment</b></p> <p><b>Inpatient Care</b> (30 Inpatient Hospital days per calendar year.)</p> <p>Physician</p> <p>Hospital      First 14 days                     Thereafter</p> <p><b>Outpatient Care</b> (30 visits per calendar year combined annual maximum and 100 visits per lifetime maximum.)</p> <p>Physician and Hospital</p>	<p>80%*</p> <p>60%* 50%*</p> <p>50%*</p>	<p>50%*</p> <p>50%*</p> <p>50%*</p>
<p><b>Medical Services Advisory (MSA®)</b></p> <p>The MSA helps you maximize your benefits.</p>	<p>The In-Network Provider is responsible for notifying MSA when services are rendered in an In-Network Hospital.</p>	<p>The Policyholder is responsible for notifying MSA for Hospital admissions at Out-of-Network and Non-Plan Hospitals.</p> <p>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.*</p>
<p><b>Mental Health Unit</b> 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.*</p>		

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

\* 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.

**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 non-payment of premium. Blue Cross and Blue Shield can refuse to renew this Policy only for the following reasons:

- A. If all Policies bearing form number DB-47 HCSC are not renewed, written notice will be provided at least 90 days before coverage is discontinued. Furthermore, you may convert to any other individual policy Blue Cross and Blue Shield offers to the individual market.
- B. In the event of fraud or an intentional misrepresentation of material fact under the terms of the coverage, written notice will be given at least 30 days before coverage is discontinued.

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### 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.

**THIS SALES KIT PROVIDES  
HEALTH INSURANCE PLAN  
HIGHLIGHTS ONLY.**

**When we receive your application, we will evaluate your medical history, and if approved, you will receive your ID card and policy.**

**Your coverage documents include a full description of benefits, limitations, exclusions and other features of coverage. You have 30 days to examine your coverage with no risk or obligation. We want you to be 100% satisfied. If you should change your mind about your Blue Cross and Blue Shield of Illinois policy, even after you've made your first premium payment, simply return your policy and membership card to your insurance representative within 30 days of the activation of the policy. If no claims were filed, you will get a refund of your premium. You'll be under no further obligation.**

A Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association

**CONSUMER MARKETS**

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