(POLICY DB-53 HCSC)

BlueCross BlueShield of Illinois

# SelecTEMP® PPO

With your choice of deductibles.

## OUTLINE OF COVERAGE

1. THIS IS A SHORT-TERM LIMITED DURATION POLICY THAT IS NON-RENEWABLE.
2. 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!
3. SelecTEMP PPO Coverage — SelecTEMP PPO coverage is designed to provide you with economic incentives for using participating 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 SelecTEMP PPO plan will be greater when you use the services of designated Hospitals and Physicians.**

| BASIC PROVISIONS | | SelecTEMP® PPO | |
|---|---|---|---|
| **Benefit Period Options** | 1 month, 2 months, 3 months 4 months, 5 months or 6 months | Participating Provider Coverage | Non-Participating Provider Coverage |
| **Lifetime Benefit** | | $5,000,000 | |
| **Deductible** Per individual (If two or more family members receive covered services as a result of injuries received in the same accident, only one Deductible will apply.) | | $500★<br>$1,000★<br>$1,500★<br>$2,000★<br>$2,500★<br>$5,000★ | $1,000★<br>$2,000★<br>$3,000★<br>$4,000★<br>$5,000★<br>$10,000★ |
| **Family Aggregate Deductible** Per family. | | 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 Deductible has been satisfied. | | 80% | 60% |
| **Out-of-Pocket Expense Limit** The amount of money an individual pays toward covered hospital and medical expenses. Items asterisked (★) do not apply to the out-of-pocket expense limit. | | $1,000 | $2,000 |
| **Family Aggregate Out-of-Pocket Expense Limit** Equal to two times the individual out-of-pocket limit, per family. | | $2,000 | $4,000 |

| BASIC PROVISIONS | SelecTEMP® PPO | |
|---|---|---|
| | Participating Provider Coverage | Non-Participating Provider Coverage |
| **Inpatient/Outpatient Physician Medical/Surgical Services** | 80% | 60% |
| **Inpatient/Outpatient Hospital Services** Includes surgery, pre-admission testing and services received in a skilled nursing facility, coordinated home care program and hospice. | 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. | 80% | 60% |
| **Physical, Occupational, and Speech Therapist Services** ($1,000 maximum combined benefit.) | 80%★ | 60%★ |
| **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 ($1,000 per month maximum★); naprapathic services rendered by a Naprapath ($500 maximum★); artificial limbs and other prosthetic devices; oxygen and its administration; blood plasma; leg, arm and neck braces; surgical dressings; casts and splints. | 80% | |
| **Outpatient Prescription Drugs** | 80% after Deductible<br>$500 maximum | |
| **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.<br>MSA notification is required within three business days for non-emergencies and within one business day or as soon as reasonably possible for emergencies. If Policyholder does not notify MSA, Hospital benefits are reduced by $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.

★ *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. Pre-existing Conditions will not be covered under the SelecTEMP PPO health insurance policy.

**TERMINATION** Coverage under this Policy will be terminated for non-payment of premium. In addition, Blue Cross and Blue Shield of Illinois can terminate this policy 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 10 days before coverage is discontinued.

## POLICY IS NOT RENEWABLE

**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; 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; Services and supplies for treatment of Mental Illness; Services and supplies for treatment of Substance Abuse; Services and supplies for treatment of Temporomandibular joint dysfunction and related disorders; 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 (Complications of Pregnancy are covered as any other illness). Services and supplies for muscle manipulation; 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.*

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