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

BasicBlue

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. BasicBlue Coverage — BasicBlue coverage is designed to provide you with economic incentives for using designated hospitals. 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 of your choice, your benefits under the BasicBlue plan will be greater when you use the services of participating Hospitals.**

BASIC PROVISIONS	BASICBLUE Participating Provider Option (PPO) Coverage
Lifetime Benefit	$5,000,000
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.	$500* $1,000* $2,500*
Family Aggregate Deductible Per family, per calendar year.	Equal to three times the individual Deductible
Hospital Admission Deductible Per admission, per individual.	$0
Coinsurance The level of coverage provided by the plan after the calendar year Deductible has been satisfied.	80%
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, emergency care copayment, charges that exceed the Usual and Customary Fee or the Eligible Charges, and items asterisked (*) do not apply to the out-of-pocket expense limit.	$1,000
Family Aggregate Out-of-Pocket Expense Limit Equal to three times the individual out-of-pocket limit, per family, per calendar year.	$3,000
Inpatient Hospital Services Includes semi-private room and board; intensive care and related miscellaneous expenses for services and supplies including pre-admission testing; prescription drugs; services of a registered physical, occupational, or speech therapist; initial expense for artificial limbs; prosthetic devices; oxygen and its administration; blood and blood plasma.	80%

BASIC PROVISIONS	BASICBLUE Participating Provider Option (PPO) Coverage
Inpatient Diagnostic Services Includes but not limited to X-rays, lab tests, EKGs, ECGs, pathology services, pulmonary function studies, radioisotope tests, and electromyograms.	80%
Outpatient Diagnostic Services Includes but is not limited to X-rays, lab tests, EKGs, ECGs, pathology services, pulmonary function studies, radioisotope tests, and electromyograms ONLY (1) when rendered on the same day as and in connection with Surgery, or (2) as part of covered emergency care.	80%
Inpatient Physician Charges (Medical/Surgical Services) For treatment due to accident or illness while an inpatient in a Hospital, Skilled Nursing Facility, or Coordinated Home Care Program; surgeon, assistant surgeon, and anesthetist fees. *Mental illness and substance abuse charges are NOT covered. Outpatient physician medical services are covered ONLY when related to (1) emergency care, and (2) postmastectomy care within 48 hours after discharge from the hospital.*	80%
Emergency Care (Hospital and Physician) Copayment applies to Covered Services received in a Hospital emergency room or a Physician's office. Copayment does not apply to Covered Services provided for the treatment of criminal sexual assault or abuse.	80% after you pay $125 copayment,*†
Outpatient Surgery Includes surgeon, assistant surgeon, and anesthetist fees; also includes surgical and anesthetic services and supplies; pre-operative tests related to the surgery.	80%
Other Outpatient Services Includes radiation therapy, chemotherapy, and renal dialysis treatments; and mammograms; and local ambulance service when related to covered Hospital admission or covered emergency care.	80%
Human Organ Tissue Transplant Includes expenses for cornea, kidney, bone marrow, heart valve, muscular/skeletal, parathyroid, heart, lung, heart/lung, liver, pancreas, pancreas/kidney, and inpatient and outpatient immunosuppressive drugs related to transplant.	80%

Medical Services Advisory (MSA®)) The MSA helps you maximize your benefits. The Participating Provider is responsible for notifying MSA when services are rendered at a Participating Hospital. The Policyholder is responsible for notifying MSA for Hospital admissions at Non-PPO 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.*

Benefits for covered services are provided at either the Eligible Charge or the Usual and Customary Fee.

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

IF USING A NON-PPO HOSPITAL OR NON-PLAN HOSPITAL...

A $300 per admission Deductible will apply in addition to the individual or family Deductible.* Hospital benefits shown above, which are paid at 80% at Participating Hospitals, are paid at 60% at Non-PPO Hospitals and 50% at Non-Plan Hospitals, except for Outpatient Hospital emergency care which is paid at 80% (after the copayment), regardless of the Hospital selected. The out-of-pocket expense limit for Non-PPO Hospitals is $5,000 for individual coverage and $15,000 for family coverage.

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-45 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-45 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.

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 or supplies for any illness or injury occurring on or after your Coverage Date as a result of war or an act of war; Services or supplies that do not meet accepted standards of medical and/or dental practice; Investigational Services and Supplies and all related services and supplies; Custodial Care Service; Outpatient Medical Care including, but not limited to, routine physical examinations; Immunizations; Outpatient Diagnostic Service except when rendered on the same day as and in connection with Surgery, as part of covered Emergency Accident Care or Emergency Medical Care, or when rendered in connection with Chemotherapy or radiation therapy treatment; Outpatient drugs or medicines except for immunosuppressive drugs prescribed in connection with a human organ transplant; Services or supplies rendered for Substance Abuse Rehabilitation Treatment or for the treatment of Mental Illness; 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; Cosmetic Surgery and related services and supplies, except for the correction of congenital deformities or for conditions resulting from accidental injuries, 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; Medical equipment or special braces, splints, specialized equipment, appliances, ambulatory apparatus, or battery controlled implants, except as specifically mentioned in this Policy; Procurement or use of prosthetic devices, special appliances, or surgical implants which are for cosmetic purposes, or unrelated to the treatment of a disease or injury; Replacement or repair of or adjustments to prosthetic devices, special appliances, or surgical implants; Private Duty Nursing Service; Eyeglasses, contact lenses, or cataract lenses and the examination for prescribing or fitting of glasses or contact lenses or for determining the refractive state of the eye; Hearing aids or examinations for the prescription or fitting of hearing aids; Services and supplies rendered in connection with Temporomandibular Joint Dysfunction and Related Disorders, except as otherwise specifically mentioned in this Policy; Treatment of flat foot conditions and the prescription of supportive devices for such conditions, treatment of subluxations of the foot, routine foot care, or corrective shoes; Outpatient Occupational, Physical, or Speech Therapy; Maternity Service, including related services and supplies; Services and supplies rendered or 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; Elective sterilization.