BlueCross BlueShield of Illinois

(POLICY DB-46 HCSC)

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 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.**

BASIC PROVISIONS	BLUE*CHOICE* SELECT	
	In-Network Provider Coverage	Out-of-Network Provider 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.	$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%
Wellness Care 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.)		
When covered services are received in a provider's office	100% after you pay $30 copayment per visit★†	50%★
When covered services are received OTHER THAN in a provider's office	100%†	50%★
Well-Child Care To age 16. Includes immunizations, physical exams and routine diagnostic tests. ($500 calendar year maximum, per dependent for non-participating provider services only.)	100% after you pay $30 copayment per visit†	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 ($3,000 maximum per therapy, per calendar year.)	80%★	50%★
Temporomandibular Joint Dysfunction and Related Disorders ($1,000 lifetime maximum.)	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%†	100%†

BASIC PROVISIONS	BLUE*CHOICE* SELECT	
	In-Network Provider Coverage	Out-of-Network Provider Coverage
Other Covered Services 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.	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 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.

★ *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.

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.*

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CONSUMER MARKETS