BlueCross BlueShield of Illinois

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 BlueChoice℠ Network	
Individual Coverage Deductible Per calendar year.	$1,250†, $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.	Calendar year deductible plus $3,000*	Calendar year deductible plus $6,000
$5,000 Deductible Option	Your calendar year deductible	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.	Calendar year deductible plus $6,000*	Calendar year deductible plus $12,000
$5,000 Deductible Option	Your calendar year deductible	Your calendar year deductible plus $10,000

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	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% 80%	80% 60%
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%
Hospital 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.