BlueCross BlueShield of Illinois

Experience. Wellness. Everywhere.℠

OUR MOST POPULAR
MAJOR MEDICAL PLANS

SelectBlue® & BlueValue℠

ALSO AVAILABLE...
NEW LOWER-COST PLANS!

SelectBlue Advantage℠ & BlueValue Advantage℠

Available to Children on an Individual Basis!

INDIVIDUAL AND FAMILY HEALTH INSURANCE

it just fits.

BlueCross BlueShield of Illinois

Experience. Wellness. Everywhere.℠

INDIVIDUAL & FAMILY HEALTH INSURANCE FOR INDIVIDUAL ADULTS, CHILDREN & FAMILIES FROM BLUE CROSS AND BLUE SHIELD OF ILLINOIS

It fits your life…and your budget!

SelectBlue

If you want a broad range of benefits, convenience and choice in a premier benefit plan, it just fits

Try this on for size...a health care plan where a $20 copayment covers doctor office visits, well-child care and more...a plan that lets you select from a wide range of deductibles, including a $0 deductible option that gives you immediate coverage for health care services...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 more of what you deserve in a health care plan...lots more. It's called SelectBlue, and it's a perfect fit for individual adults, individual children and families who need a broad range of benefits. In fact, SelectBlue provides a level of individual health care coverage previously found only in employer-sponsored group health care plans!

BlueValue

Your ideal option for reliable health insurance coverage at rates to fit your budget

If you're looking for a wide scope of benefits with a lower premium, consider our BlueValue plan. Like SelectBlue, BlueValue offers reliable benefits — including coverage for hospitalization, doctor office visits, emergency care, outpatient prescription drugs, well-child care and optional maternity care.

Because BlueValue **leaves out** features such as a $20 doctor office visit copayment and a $0 deductible option, you can enjoy a lower monthly premium. If you're looking for a combination of benefits and choice at a price that fits your budget, BlueValue has it!

SelectBlue

OUR PREMIER MAJOR MEDICAL PLAN FOR INDIVIDUAL ADULTS, CHILDREN & FAMILIES...

$20 Office Visit Copayment

With SelectBlue, you pay only a $20 office visit copayment when you use participating providers. You simply pay your doctor $20 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 a $20 copayment per visit with SelectBlue.

SelectBlue 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 $20 office visit copayment when you use participating providers!

A Choice of Deductibles, Including a $0 Deductible Option

For the most coverage, Blue Cross and Blue Shield of Illinois gives you the opportunity to choose a $0 deductible exclusively with SelectBlue. That means the plan starts paying benefits for covered services immediately. SelectBlue also offers a choice of a $250, $500, $1,000, $2,500 or $5,000 deductible. Whatever your budget, we have an option for you.

Select Your Coverage Level to Control Your Costs: 100% or 80%

The coverage level (percentage) that SelectBlue pays for covered services after you meet your deductible, if any, is called coinsurance. With 100% coinsurance, you pay nothing for most covered services once your deductible has been met when you use participating providers. With 80% coinsurance, you pay 20% of your eligible bills until you've paid $1,000 (after you've met your deductible and when you use participating providers). At that point, SelectBlue goes on to pay 100% of these services for the remainder of the calendar year.

The Security of $5,000,000 in Lifetime Protection

With SelectBlue, individual adults, individual children and families may apply for coverage. Family coverage protects you, your spouse and your eligible unmarried dependent children. 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 SelectBlue, you get coverage for outpatient prescription medications.

When you choose a $0, $250 or $500 deductible:

Simply present your prescription drug card at participating pharmacies and pay $10 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, $2,500 or $5,000 deductible with SelectBlue:

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!

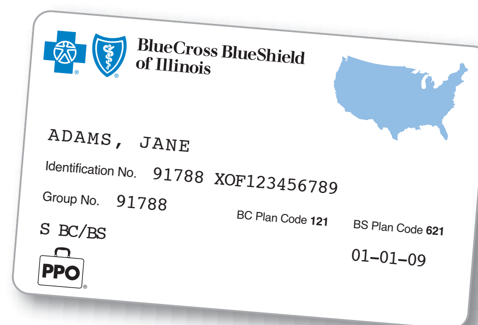
For a Premium Savings Advantage, Consider…

SelectBlue Advantage

If you like the covered services offered with SelectBlue and are willing to share more out-of-pocket costs in return for a lower premium, consider SelectBlue Advantage. Like SelectBlue, it offers a wide range of benefits for hospitalization, doctor office visits, outpatient prescriptions, well-adult care, well-child care and more. Because SelectBlue Advantage offers additional cost-sharing features, such as a $30 copayment for doctor office visits, a $75 copayment for emergency care and a higher out-of-pocket expense limit, you can save on premiums. So if you like what SelectBlue has to offer, but want a more affordable premium rate, consider SelectBlue Advantage!

BlueValue

FOR RELIABLE MAJOR MEDICAL BENEFITS AT A LOWER PREMIUM



For Choice and Value, Choose BlueValue!

Like SelectBlue, BlueValue offers reliable benefits for doctor office visits, outpatient services, well-child care, emergency care and more. By leaving out some of the features offered in SelectBlue, such as the doctor office visit copayment and the prescription drug card, you get value in a highly flexible plan. Take a closer look at the coverage and value you can get with BlueValue. You'll see why it has become our most popular major medical plan!

A Choice of Deductibles with BlueValue

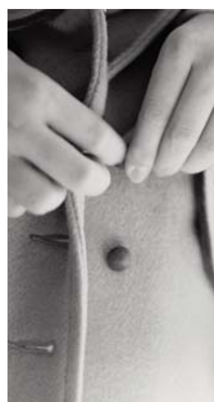
BlueValue offers a choice of a $250, $500, $1,000, $2,500 or $5,000 deductible. Whatever your budget, we have an option for you.

Select Your Coverage Level to Control Your Costs: 100% or 80%

The coverage level (percentage) that BlueValue pays for covered services after you meet your deductible is called coinsurance. With 100% coinsurance, coverage begins for most covered services once your deductible has been met when you use participating providers. With 80% coinsurance, you pay 20% of your eligible bills until you've paid $1,000 (after you've met your deductible, and when you use participating providers). At that point, BlueValue goes on to pay 100% of these services for the remainder of the calendar year.

The Security of $5,000,000 in Lifetime Protection

With BlueValue, individual adults, individual children and families may apply for coverage. Family coverage protects you, your spouse and your eligible unmarried dependent children. 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 with Any Deductible You Choose

With BlueValue, you get significant coverage for outpatient prescription medications. 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!

For Even Lower Premiums, Consider…

BlueValue Advantage

If you like the covered services offered with BlueValue and are willing to share more out-of-pocket costs in return for a lower premium, consider BlueValue Advantage. Like BlueValue, it offers reliable benefits for hospitalization, doctor office visits, outpatient prescriptions, well-child care and more. Because BlueValue Advantage offers additional cost-sharing features, including a $75 copayment for emergency care and a higher out-of-pocket expense limit, you can save on premiums. So if you like the coverage and affordability BlueValue has to offer, but want an even lower premium, consider BlueValue Advantage!

The Size and Strength of the Provider Network Assures You Freedom of Choice

SelectBlue and BlueValue provide access to one of the largest provider networks in Illinois. In fact, with 90% of Illinois doctors included — as well as more than 200 hospitals — it's likely that your current health care providers participate.

Blue Cross and Blue Shield of Illinois Offers You and Eligible Family Members Choices

Blue Cross and Blue Shield of Illinois offers you and eligible family members choice when it comes to your care. Members and eligible dependents have the freedom to visit any physician they choose, with benefits paid at the maximum level when the doctor is in the participating provider network. Members do not need to select a primary care physician to coordinate care and no referrals are needed to see a specialist.

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 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. To find a participating provider while you're away, just call the toll-free number on the back of your card. It's that easy.

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. We want you to concentrate on your health — not worrying about hospital and doctor bills.

Illinois Residents Choose Blue Cross and Blue Shield of Illinois

Guaranteed Renewability

Your individual or family coverage is guaranteed renewable. This means that 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 out of three carries a Blue Cross and Blue Shield membership card. In fact, over 6.5 million residents across Illinois trust Blue Cross and Blue Shield of Illinois to give them more health care value for their premium dollar. Blue Cross and Blue Shield of Illinois has been serving the health insurance needs of Illinois residents for over 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+" (Superior) rating.*

* As of November 2007

PRODUCER'S NEW BUSINESS CHECKLIST

For quick processing of all applications…

Use this simple checklist before submitting your applications to assure prompt processing.

Have you:

- ☐ Reviewed each application to verify that it is complete and legible?
- ☐ Assured that all the necessary signatures are provided?
- ☐ Assured that a separate application has been completed for each child applying for individual coverage?
- ☐ Assured that any changes to an application are initialed by the applicant?
- ☐ Attached detailed descriptions for any health questions which have been answered "YES"?
- ☐ Included your Agent Code and phone number on the application?
- ☐ Completed the "Conditional Receipt" form?
- ☐ Given the applicant a copy of the Outline of Coverage?

IMPORTANT!

Use this checklist to make sure you've completed all needed information.

In addition…

- ☐ There are NO C.O.D.s.
- ☐ The check for the exact amount should be made payable to: Blue Cross and Blue Shield of Illinois.

  If applicant is paying by bank draft authorization, make sure the authorization form is completed, a voided check or deposit slip is attached, and a check for the first month's premium is submitted.

  If applicant is selecting the two-month payment mode, a check for the first two months' premium should be submitted.
- ☐ If applicant is replacing his/her current coverage, make sure a signed replacement form is also attached.

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
® Registered Service Marks of the Blue Cross and Blue Shield Association, an Association of Independent Blue Cross and Blue Shield Plans
SM Service Marks of Health Care Service Corporation

30155.0109 IL

BlueCross BlueShield of Illinois

Experience. Wellness. Everywhere.℠

(POLICY DB-48 HCSC)

SelectBlue Advantage℠

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. SelectBlue Advantage Coverage — SelectBlue Advantage 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 SelectBlue Advantage plan will be greater when you use the services of participating Hospitals and Physicians.**

BASIC PROVISIONS	SELECTBLUE ADVANTAGE	
	Participating Provider Coverage	Non-Participating 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*	
Family Aggregate Deductible Per family, per calendar year.	Equal to three 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 three times the individual out-of-pocket limit, per family, per calendar year.	$9,000	$18,000

BASIC PROVISIONS	SELECTBLUE ADVANTAGE	
	Participating Provider Coverage	Non-Participating 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%†	

BASIC PROVISIONS	SELECTBLUE ADVANTAGE	
	Participating Provider Coverage	Non-Participating Provider Coverage
Other Covered Services Ambulance services; services of a private duty nursing service ($1,000 per month maximum★); naprapathic services rendered by a Naprapath ($1,000 per calendar year maximum★); oxygen and its administration; blood plasma; 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 Non-Participating and Non-Plan Hospitals. (MSA notification by the Policyholder is NOT required when services are rendered in a Participating 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	SELECTBLUE ADVANTAGE 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.

Durable Medical Equipment (DME) providers, Orthotic providers and Prosthetic providers are participating providers. Please refer to your Policy Book for details.

★ *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 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. 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-48 HCSC policies. Premiums can be changed based on age, sex, and rating area.

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 this Policy form number, DB-48 HCSC, is 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 this Policy form number only on the coverage Renewal Date.

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

®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

SM Service Mark of Health Care Service Corporation

BlueCross BlueShield of Illinois

Experience. Wellness. Everywhere.℠

BlueValue Advantage℠

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. BlueValue Advantage Coverage — BlueValue Advantage 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 BlueValue Advantage plan will be greater when you use the services of participating Hospitals and Physicians.**

BASIC PROVISIONS	BLUEVALUE ADVANTAGE	
	Participating Provider Coverage	Non-Participating 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★	
Family Aggregate Deductible Per family, per calendar year.	Equal to three 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 three times the individual out-of-pocket limit, per family, per calendar year.	$9,000	$18,000

BASIC PROVISIONS	BLUEVALUE ADVANTAGE	
	Participating Provider Coverage	Non-Participating Provider Coverage
Inpatient/Outpatient Physician Medical/Surgical Services	80%	50%
Well-Child Care To age 16. Includes immunizations, physical exams, and routine diagnostic tests. ($500 per calendar year maximum, per dependent.)	80%	50%★
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.)	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%†	
Other Covered Services Ambulance services; services of a private duty nursing service ($1,000 per month maximum★); naprapathic services rendered by a Naprapath ($1,000 per calendar year maximum★); oxygen and its administration; blood plasma; surgical dressings; casts and splints; and outpatient prescription drugs.	80%	

BASIC PROVISIONS	BLUEVALUE ADVANTAGE	
	Participating Provider Coverage	Non-Participating Provider Coverage
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%★
Hospital — 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®´) 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. 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.★

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.★

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

Durable Medical Equipment (DME) providers, Orthotic providers and Prosthetic providers are participating providers. Please refer to your Policy Book for details.

★ *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. 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-49 HCSC policies. Premiums can be changed based on age, sex, and rating area.

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 this Policy form number, DB-49 HCSC, is 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 this Policy form number only on the coverage Renewal Date.

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.*

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

® 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
SM Service Mark of Health Care Service Corporation

BlueCross BlueShield of Illinois

Experience. Wellness. Everywhere.℠

BlueValue℠

With your choice of deductibles and participating provider coinsurance levels.

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. BlueValue Coverage — BlueValue 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 BlueValue plan will be greater when you use the services of participating Hospitals and Physicians.**

BASIC PROVISIONS	BLUEVALUE	
	Participating Provider Coverage	Non-Participating 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* $2,500* $5,000*	
Family Aggregate Deductible Per family, per calendar year.	Equal to three 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%
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 and/or the Mental Health Unit, charges that exceed the Maximum Allowance or the Eligible Charges, and items asterisked (*) do not apply to the out-of-pocket expense limit.	$1,000	$4,000
Family Aggregate Out-of-Pocket Expense Limit Equal to three times the individual out-of-pocket limit, per family, per calendar year.	$3,000	$12,000

BASIC PROVISIONS	BLUEVALUE	
	Participating Provider Coverage	Non-Participating Provider Coverage
Inpatient/Outpatient Physician Medical/Surgical Services	100% 80%	80% 60%
Well-Child Care To age 16. Includes immunizations, physical exams, and routine diagnostic tests. ($500 per calendar year maximum, per dependent.)	100% 80%	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. (For mental health coverage levels, please refer to mental health benefits on the next page.)	100% 80%	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.	100% 80%	80% 60%
Physical, Occupational, and Speech Therapist Services ($3,000 maximum per therapy, per calendar year.)	100% 80%★	80%★ 60%★
Temporomandibular Joint Dysfunction and Related Disorders ($1,000 lifetime maximum.)	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%†	
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 ($1,000 per calendar year maximum★); oxygen and its administration; blood plasma; surgical dressings; casts and splints; and outpatient prescription drugs.	80%	

BASIC PROVISIONS	BLUEVALUE	
	Participating Provider Coverage	Non-Participating Provider Coverage
Mental Illness Treatment and Substance Abuse Rehabilitation Treatment★★		
Inpatient Care (30 Inpatient Hospital days per calendar year.)	100%	80%★
Physician	80%★	60%★
Hospital — First 14 days	60%★	50%★
Hospital — 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®´) 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. 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.★

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 for emergencies. Failure to contact the Mental Health Unit may result in a reduction of benefits of up to $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.

Durable Medical Equipment (DME) providers, Orthotic providers and Prosthetic providers are participating providers. Please refer to your Policy Book for details.

★ *Does not apply to out-of-pocket expense limit.*

★★ *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.*

† *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, with the exception of alcoholism, no benefits are available for Substance Abuse Rehabilitation Treatment. Also, Outpatient Hospital and Physician emergency care, and additional surgical opinions are paid at 100%, regardless of the coverage level or Provider selected.

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-42 HCSC policies. Premiums can be changed based on age, sex, and rating area.

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 this Policy form number, DB-42 HCSC, is 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 this Policy form number only on the coverage Renewal Date.

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).

* *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

® 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
SM Service Mark of Health Care Service Corporation

BlueCross BlueShield of Illinois

Experience. Wellness. Everywhere.℠

(POLICY DB-43 HCSC)

SelectBlue®

With your choice of deductibles and participating provider coinsurance levels.

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. SelectBlue Coverage — SelectBlue 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 SelectBlue plan will be greater when you use the services of participating Hospitals and Physicians.**

BASIC PROVISIONS	SELECTBLUE	
	Participating Provider Coverage	Non-Participating 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.	$0* $250* $500* $1,000* $2,500* $5,000*	
Family Aggregate Deductible Per family, per calendar year.	Equal to three 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%
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.	$1,000	$4,000
Family Aggregate Out-of-Pocket Expense Limit Equal to three times the individual out-of-pocket limit, per family, per calendar year.	$3,000	$12,000

BASIC PROVISIONS	SELECTBLUE	
	Participating Provider Coverage	Non-Participating 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 $20 copayment per visit★†	80%
	100% after you pay $20 copayment per visit★†	60%
Surgery, therapy, and certain diagnostic services including MRI, CT scan, pulmonary function studies, cardiac catheterization, EEG, EKG, ECG, and Swan-Ganz catheterization.	100%	80%
	80%	60%
Inpatient Physician Medical/Surgical Services	100%	80%
	80%	60%
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 $20 copayment per visit★†	80%★
	100% after you pay $20 copayment per visit★†	60%★
When covered services are received OTHER THAN in a provider's office	100%†	80%★
	100%†	60%★
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 $20 copayment per visit†	80%★
	100% after you pay $20 copayment per visit†	60%★
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.)	100%	80%
	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.	100%	80%
	80%	60%
Physical, Occupational, and Speech Therapist Services ($3,000 maximum per therapy, per calendar year.)	100%	80%★
	80%★	60%★
Temporomandibular Joint Dysfunction and Related Disorders ($1,000 lifetime maximum.)	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%†	
Additional Surgical Opinion Program Following a recommendation for elective surgery, provides additional consultations and related diagnostic service by a Physician, as needed.	100%†	

BASIC PROVISIONS	SELECTBLUE	
	Participating Provider Coverage	Non-Participating Provider Coverage
Other Covered Services Ambulance services; services of a private duty nursing service ($1,000 per month maximum*); naprapathic services rendered by a Naprapath ($1,000 per calendar year maximum*); oxygen and its administration; blood plasma; surgical dressings; casts and splints.	80%	
Mental Illness Treatment and Substance Abuse Rehabilitation Treatment**		
Inpatient Care (30 Inpatient Hospital days per calendar year.)	100%	80%*
Physician	80%*	60%*
Hospital — First 14 days	60%*	50%*
Hospital — 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 Non-Participating and Non-Plan Hospitals. (MSA notification by the Policyholder is NOT required when services are rendered in a Participating Hospital.) MSA notification is required within three business days for non-emergencies and within one business day 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 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	SELECTBLUE PAYS
	Participating Pharmacy††	Participating Pharmacy††
$0, $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.		
$1,000, $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.

Durable Medical Equipment (DME) providers, Orthotic providers and Prosthetic providers are participating providers. Please refer to your Policy Book for details

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

** *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.*

† *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, with the exception of Alcoholism, no benefits are available for Substance Abuse Rehabilitation Treatment. Also, Outpatient Hospital and Physician emergency care and additional surgical opinions are paid at 100%, regardless of the coverage level or Provider selected.

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-43 HCSC policies. Premiums can be changed based on age, sex, and rating area.

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 this Policy form number, DB-43 HCSC, is 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 this Policy form number only on the coverage Renewal Date.

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).

* *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

®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

Blue Cross and Blue Shield of Illinois (BCBSIL) Individual Coverage Plan Selection

BlueCross BlueShield of Illinois

To help us process your application promptly, please remember:

HOME OFFICE USE ONLY

- **You must complete and submit the Illinois Standard Health Application for Individual and Family Coverage in addition to this Individual Coverage Plan Selection form to apply for a BCBSIL insurance plan.**
- Please print clearly in **blue or black ink**. Pencil will not be accepted.
- In addition to having a permanent residence in Illinois, all persons applying for coverage who are not U.S. citizens must have resided in the U.S. for at least six months ***AND*** have had a complete physical by a physician in the U.S. within the past two years.
- BCBSIL individual insurance plans do not cover domestic partners.

SECTION A — PRIMARY APPLICANT INFORMATION (please print)

First Name	Middle Initial	Last Name	Date of Birth	Gender ☐ M ☐ F

Residential Street Address *(no P.O. Boxes)*	City / State / ZIP

County	Primary Phone # ☐ Home ☐ Cell ☐ Business ( )

E-mail

CHECK ONE of the following boxes: ☐ New Business ☐ Plan Upgrade ☐ Add Spouse or Child(ren)

SECTION B — PLAN SELECTION: (please choose only one health plan with one deductible and one level of coverage)

☐ **SelectBlue®**
Deductible: ☐ $0 ☐ $250 ☐ $500 ☐ $1,000 ☐ $2,500 ☐ $5,000
Level of Coverage: ☐ 100% ☐ 80%

☐ **SelectBlue Advantage℠**
Deductible: ☐ $250 ☐ $500 ☐ $1,000 ☐ $1,750 ☐ $2,500 ☐ $5,000
Level of Coverage: ☐ 80%

☐ **Blue*Choice*℠ Select**
Deductible: ☐ $250 ☐ $500 ☐ $1,000 ☐ $1,750 ☐ $2,500 ☐ $5,000
Level of Coverage: ☐ 80%

☐ **BlueValue℠**
Deductible: ☐ $250 ☐ $500 ☐ $1,000 ☐ $2,500 ☐ $5,000
Level of Coverage: ☐ 100% ☐ 80%

☐ **BlueValue Advantage℠**
Deductible: ☐ $250 ☐ $500 ☐ $1,000 ☐ $1,750 ☐ $2,500 ☐ $5,000
Level of Coverage: ☐ 80%

☐ **Blue*Choice*℠ Value**
Deductible: ☐ $250 ☐ $500 ☐ $1,000 ☐ $1,750 ☐ $2,500 ☐ $5,000
Level of Coverage: ☐ 80%

☐ **BlueEdge℠ Individual HSA**
Deductible:
☐ $1,200 for a single applicant or $2,400 for a family*
☐ $1,750 for a single applicant or $3,500 for a family
☐ $2,600 for a single applicant or $5,200 for a family
☐ $3,500 for a single applicant or $7,000 for a family
Level of Coverage: ☐ 100% ☐ 80%

** The deductible amount will be adjusted automatically if the amount is lower than the amount required by law.*

☐ **BlueEdge℠ Individual HSA 5000**
Deductible: $5,000 for a single applicant or $10,000 for a family
Level of Coverage: ☐ 100%

OPTIONAL COVERAGE:

☐ **Include Maternity Coverage?**
You MUST choose a health plan in order to apply for maternity coverage.

☐ **BlueCare® Dental PPO**
You MUST choose a health plan in order to apply for dental.

SECTION C — CURRENT OR PREVIOUS BCBS COVERAGE

Does any person applying for coverage currently have, or did they previously have **within the last 5 years**, Blue Cross and Blue Shield coverage, either as a primary insured, spouse or as a dependent? ☐ **Yes** ☐ **No** ***If "yes", please complete the following:***

Applicant Name ______________________ Name on Previous Policy *(if applicable)* ______________________ Member/Group# *(optional)* ______________ State __________

Applicant Name: ______________________ Name on Previous Policy *(if applicable)* ______________________ Member/Group# *(optional)* ______________ State __________

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

SECTION D — BILLING INFORMATION

Note: Do not cancel any current coverage you may have until your new policy is approved and in force.

PREMIUM AMOUNT ENCLOSED: $____________________

PAYMENT OPTION (Select One): ☐ **A**. Monthly Bank Draft ☐ **B**. Two-Month Direct Bill

☐ **C**. List Bill (submit a "Personal Health Insurance Certificate for Employees" form with the application) *See Name of Employer box below.*

Option A Information Required: Name of Bank, City and State where account is authorized ______________________________

____

Please check one: ☐ Checking Account ☐ Savings Account

Bank Transit Number:____

Depositor's Account Number: ____

Depositor's Signature:____ Date __________________

Options B & C Information Required: Billing Name and Address (If different than applicant name and residential address. If an address is entered in this section, only the billing will be sent to this address; all other correspondence will be sent to the address in Section A, unless you request otherwise.) Name of Employer is required if Option C is chosen.

First Name, Middle Initial, Last Name	
Billing Street Address *(P.O. Boxes acceptable)*	City / State / ZIP
Name of Employer *(if requesting Payment Option C. List Bill only)*	

SECTION E — PROXY INFORMATION

PROXY The undersigned hereby appoints the Board of Directors of Health Care Service Corporation, a Mutual Legal Reserve Company, or any successor thereof ("HCSC"), with full power of substitution, and such persons as the Board of Directors may designate by resolution, as the undersigned's proxy to act on behalf of the undersigned at all meetings of members of HCSC (and at all meetings of members of any successor of HCSC) and any adjournments thereof, with full power to vote on behalf of the undersigned on all matters that may come before any such meeting and any adjournment thereof. The annual meeting of members shall be held each year in the corporate headquarters on the last Tuesday of October at 12:30 p.m. Special meetings of members may be called pursuant to notice mailed to the member not less than 30 nor more than 60 days prior to such meetings. This proxy shall remain in effect until revoked in writing by the undersigned at least 20 days prior to any meeting of members, or by attending and voting in person at any annual or special meeting of members.

Primary Applicant Signature *(optional)*: X ____

Print Your Name as You Signed It: ______________________________ **Date Signed:** ______ **/** ______**/** ______
Mo./Day/Yr.

SECTION F — REQUIRED SIGNATURES (AGENT, IF APPLICABLE)

I certify that I have received the required Outline of Coverage.

Primary Applicant Signature: X ______________________________ **Date Signed:** ______ **/** ______**/** ______
Mo./Day/Yr.

Agent Signature: X ______________________________ **Date Signed:** ______ **/** ______**/** ______
Mo./Day/Yr.

Print Agent Name: ______________________________ **Agent Code:** ______________

Agent Phone Number: ( ) ______________________________ **Agent Fax Number:** ( ) ______________

Agent Email Address:____

Mail Policy(ies) to: ☐ **Agent** ☐ **Applicant**

We must also receive your application within 60 days of the earliest date signed, so please return promptly. Applications received after 60 days will require a new application.

Coverage for preexisting medical conditions may be excluded or be subject to a waiting period of up to 24 months including for dependents under age 19 being added to a policy that was in effect prior to 3/23/10.

QUESTIONS?

1. Call our Customer Service Department toll-free at **1-800-654-7385**
2. Call your insurance agent
3. Visit **bcbsil.com**

Changes in state or federal law or regulations or interpretations thereof may change the terms and conditions of coverage.

Illinois Standard Health Application for Individual & Family Health Insurance Coverage

For assistance in completing this application, please contact your insurance agent or the insurance company directly. For information about your health insurance rights under state and federal law, and other resources, please contact the Illinois Department of Insurance's Office of Consumer Health Insurance toll free at (877) 527-9431.

INSTRUCTIONS:

1. Any information you provide in this application is confidential.
2. The answers you provide in this application must be true and complete, to the best of your knowledge and belief. Do not leave any question unmarked.
3. An intentional misrepresentation may result in your policy being modified or terminated, or in claims being reduced or denied.
4. For purposes of this application, the term "dependent" refers to any child up to age 26 (or age 30 for military veterans) for whom you are requesting coverage, regardless of whether the child may be considered a dependent for tax or other purposes. For information about Illinois' Young Adult Dependent Coverage law, which allows parents to cover children up to age 26, and up to age 30 for military veterans, please visit the Illinois Department of Insurance website at www.insurance.illinois.gov.

A Primary Applicant Information

Name (Last)	(First)	(MI)
Residential Street Address:		Apt #:
City:	State:	Zip:
Mailing Address (if different):		Apt #:
City:	State:	Zip:
Primary Phone Number: ( )	Best time to call: ☐ Morning ☐ Afternoon ☐ Evening	
Secondary Phone Number: ( )	Best time to call: ☐ Morning ☐ Afternoon ☐ Evening	
Email Address (optional):		
Please check one of the following boxes: ☐ New Application ☐ Dependent Addition ☐ Plan Change ☐ Reinstatement		
Requested Effective Date: ______________________ (Coverage not in force until the insurance carrier approves your application and determines the effective date.)		

B Employment Information

Occupation:	Job Title:
Spouse/Domestic Partner's Occupation:	Job Title:
Currently employed? (optional) Self: ☐ Yes ☐ No Spouse/Domestic Partner: ☐ Yes ☐ No	

PRIMARY APPLICANT NAME ______________________ DATE ______________

C Persons Requesting Coverage

List all family members you wish to include under the policy. Insurance companies may have different rules about who may qualify as an eligible dependent. For more information regarding the available coverage, please check with your insurance agent or insurance carrier.

Note: For purposes of this application, an "eligible military veteran" is a veteran who served in the active or reserve components of the U.S. Armed Forces, including the National Guard, and who received a release or discharge other than a dishonorable discharge.

If additional space is required, please attach a separate sheet and be sure to sign and date that sheet.

Self Name (Last) ______________ (First) ______________ (MI) ______

Social Security Number (for internal use only):	Date of Birth: / /
State of Birth (country if born outside the U.S.):	Gender: ☐ Male ☐ Female
Percentage of time annually spent outside of Illinois for residence, work, or school:	

Spouse/Domestic Partner Name (Last) ______________ (First) ______________ (MI) ______

Social Security Number (for internal use only):	Date of Birth: / /
State of Birth (country if born outside the U.S.):	Gender: ☐ Male ☐ Female
Percentage of time annually spent outside of Illinois for residence, work, or school:	

Dependent Name (Last) ______________ (First) ______________ (MI) ______

Relationship to Applicant:	Date of Birth: / /
Social Security Number (for internal use only):	Gender: ☐ Male ☐ Female
Eligible Military Veteran: ☐ Yes ☐ No	
Percentage of time annually spent outside of Illinois for residence, work, or school:	

Dependent Name (Last) ______________ (First) ______________ (MI) ______

Relationship to Applicant:	Date of Birth: / /
Social Security Number (for internal use only):	Gender: ☐ Male ☐ Female
Eligible Military Veteran: ☐ Yes ☐ No	
Percentage of time annually spent outside of Illinois for residence, work, or school:	

Dependent Name (Last) ______________ (First) ______________ (MI) ______

Relationship to Applicant:	Date of Birth: / /
Social Security Number (for internal use only):	Gender: ☐ Male ☐ Female
Eligible Military Veteran: ☐ Yes ☐ No	
Percentage of time annually spent outside of Illinois for residence, work, or school:	

70670

PRIMARY APPLICANT NAME ____________________ DATE ____________

Dependent Name (Last) ______________ (First) ______________ (MI) ______

Relationship to Applicant: | Date of Birth: / /

Social Security Number (for internal use only): | Gender: ☐ Male ☐ Female

Eligible Military Veteran: ☐ Yes ☐ No

Percentage of time annually spent outside of Illinois for residence, work, or school:

D Current/Prior Coverage Information

For EACH person listed on this application, please indicate any public health insurance coverage (for example, Medicare, HFS Medical Card, All Kids, Family Care, or other federal and state programs) or private health insurance in effect within the **last 12 months**. Each person applying for insurance must be listed below. If health insurance coverage was not in effect within the **last 12 months**, please indicate **NONE.**

Self Name (Last) ______________ (First) ______________ (MI) ______

▶ **Current/Most Recent Coverage**:

☐ None ☐ Medicare ☐ Other Public ☐ Private (Insurer: ______________________)

▶ **Dates of Coverage**: From: ____/____/____ To: ____/____/____

▶ Is the issuance of this coverage **replacing** your existing coverage?* ☐ Yes ☐ No

▶ **Prior Coverage (if any)**:

☐ None ☐ Medicare ☐ Other Public ☐ Private (Insurer: __________ ______________)

▶ **Dates of Coverage**: From: ____/____/____ To: ____/____/____

Spouse/Domestic Partner Name (Last) ______________ (First) ______________ (MI) ____

▶ **Current/Most Recent Coverage**:

☐ None ☐ Medicare ☐ Other Public ☐ Private (Insurer: ______________________)

▶ **Dates of Coverage**: From: ____/____/____ To: ____/____/____

▶ Is the issuance of this coverage **replacing** your existing coverage?* ☐ Yes ☐ No

▶ **Prior Coverage (if any)**:

☐ None ☐ Medicare ☐ Other Public ☐ Private (Insurer: __________ ______________)

▶ **Dates of Coverage**: From: ____/____/____ To: ____/____/____

Dependent Name (Last) ______________ (First) ______________ (MI) ______

▶ **Current/Most Recent Coverage**:

☐ None ☐ Medicare ☐ Other Public ☐ Private (Insurer: ______________________)

▶ **Dates of Coverage**: From: ____/____/____ To: ____/____/____

▶ Is the issuance of this coverage **replacing** your existing coverage?* ☐ Yes ☐ No

▶ **Prior Coverage (if any)**:

☐ None ☐ Medicare ☐ Other Public ☐ Private (Insurer: __________ ______________)

▶ **Dates of Coverage**: From: ____/____/____ To: ____/____/____

PRIMARY APPLICANT NAME ______________________ DATE ______________

Dependent Name (Last) ____________ (First) ____________ (MI) ____

▶ **Current/Most Recent Coverage**:
☐ None ☐ Medicare ☐ Other Public ☐ Private (Insurer: ____________________)
▶ **Dates of Coverage**: From: ____/____/____ To: ____/____/____
▶ Is the issuance of this coverage **replacing** your existing coverage?✶ ☐ Yes ☐ No

▶ **Prior Coverage (if any)**:
☐ None ☐ Medicare ☐ Other Public ☐ Private (Insurer: ____________________)
▶ **Dates of Coverage**: From: ____/____/____ To: ____/____/____

Dependent Name (Last) ____________ (First) ____________ (MI) ____

▶ **Current/Most Recent Coverage**:
☐ None ☐ Medicare ☐ Other Public ☐ Private (Insurer: ____________________)
▶ **Dates of Coverage**: From: ____/____/____ To: ____/____/____
▶ Is the issuance of this coverage **replacing** your existing coverage?✶ ☐ Yes ☐ No

▶ **Prior Coverage (if any)**:
☐ None ☐ Medicare ☐ Other Public ☐ Private (Insurer: ____________________)
▶ **Dates of Coverage**: From: ____/____/____ To: ____/____/____

Dependent Name (Last) ____________ (First) ____________ (MI) ____

▶ **Current/Most Recent Coverage**:
☐ None ☐ Medicare ☐ Other Public ☐ Private (Insurer: ____________________)
▶ **Dates of Coverage**: From: ____/____/____ To: ____/____/____
▶ Is the issuance of this coverage **replacing** your existing coverage?✶ ☐ Yes ☐ No

▶ **Prior Coverage (if any)**:
☐ None ☐ Medicare ☐ Other Public ☐ Private (Insurer: ____________________)
▶ **Dates of Coverage**: From: ____/____/____ To: ____/____/____

✶ If answering **"YES"** please carefully read the following notice.

NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT & HEALTH INSURANCE

According to information you have furnished, you intend to lapse or otherwise terminate existing accident and health insurance and replace it with a policy to be issued by the insurance carrier. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

1. Health conditions which you may presently have (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.
2. You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interests to make sure you understand all the relevant factors involved in replacing your present coverage.
3. If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical/health history. Failure to include all material medical information on an application may provide a basis for the insurance carrier to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, re-read it carefully to be certain that all information has been properly recorded.
4. It is recommended that you do not terminate your present contract until you are certain that your application for the new contract has been approved by the insurance carrier.

PRIMARY APPLICANT NAME ___________________________________ DATE ________________________

DEPENDENT NAME (If submitted separately) ____

E Health Statement

The federal **Genetic Information Nondiscrimination Act** prohibits health insurers from asking for and using **"genetic information"** when deciding whether to offer coverage and how much to charge for coverage. For more information on the Genetic Information Nondiscrimination Act, please visit the Illinois Department of Insurance website at www.insurance.illinois.gov.

Instructions:

1. Each medical question below applies to each person requesting coverage.
2. Answer the questions below by checking Yes or No. If you answer Yes to any question, you must provide additional information in Section F below.
3. Do not leave any question unmarked.

Limited Privacy Available: Persons age 18 or older may submit a signed and dated separate health statement. The information provided in such separate health statement(s) will likely be disclosed to the primary applicant.

1 For any of the following conditions, **within the past FIVE (5) years**, has anyone applying for coverage:

- Been diagnosed with;
- Had treatment or testing recommended;
- Received treatment, including prescription medications; or
- Been hospitalized for any illness, injury, or health condition listed below?

If answering "YES," check all that apply.

A. **Heart/Circulatory Conditions/Disorders:** ☐ Yes ☐ No

▶ **Heart:** ☐ Heart attack ☐ Chest pain ☐ Heart murmur ☐ Irregular heartbeat
☐ High/elevated blood pressure* ☐ High/elevated cholesterol*
✶ If applicable, please provide last known blood pressure or cholesterol reading in Section F.

▶ **Circulatory:** ☐ Anemia ☐ Bleeding/clotting disorder ☐ Varicose/spider veins ☐ Phlebitis

B. **Lymphatic Conditions/Disorders:** ☐ Yes ☐ No

☐ Lymphadenopathy ☐ Enlarged lymph nodes ☐ Disease of the spleen

C. **Cancer/Tumors/Growths:** ☐ Yes ☐ No

☐ Cancer ☐ Tumors ☐ Cysts ☐ Polyps ☐ Lumps ☐ Other abnormal growths

D. **Respiratory Conditions/Disorders:** ☐ Yes ☐ No

☐ Asthma ☐ Bronchitis ☐ Emphysema ☐ Sleep apnea ☐ Pneumonia ☐ Tuberculosis
☐ Chronic obstructive pulmonary disease (COPD)

E. **Intestinal/Digestive Conditions/Disorders:** ☐ Yes ☐ No

☐ Acid reflux ☐ Ulcers ☐ Hernia *(indicate type)* ☐ Colitis ☐ Hemorrhoids ☐ Rectal bleeding ☐ Gallstones
☐ Irritable bowel syndrome ☐ Chronic diarrhea ☐ Hepatitis *(indicate type)* ☐ Elevated liver function test
☐ Jaundice ☐ Cirrhosis ☐ Gallbladder infection or inflammation ☐ Pancreatitis ☐ Crohn's disease

F. **Urinary Conditions/Disorders:** ☐ Yes ☐ No

☐ Kidney infection ☐ Kidney stones ☐ Bladder infection ☐ Cystitis ☐ Urinary reflux ☐ Urinary tract infection

G. **Metabolic/Endocrine Conditions/Disorders:** ☐ Yes ☐ No

☐ Diabetes ☐ Thyroid disorder ☐ High/low blood sugar ☐ Adrenal, pituitary, or other glandular disorder
☐ Chronic fatigue syndrome ☐ Obesity/weight loss surgery

PRIMARY APPLICANT NAME ______________________________ DATE ____________________

DEPENDENT NAME (If submitted separately) ____

H. Brain/Nervous System Conditions/Disorders: ☐ Yes ☐ No

☐ Seizures ☐ Migraine headaches/Chronic severe headaches ☐ Head injury ☐ Paralysis ☐ Epilepsy ☐ Tremor
☐ Stroke or TIA ☐ Multiple sclerosis ☐ Parkinson's ☐ Restless leg syndrome ☐ Lou Gehrig's disease (ALS)

I. Immune System Conditions/Disorders: ☐ Yes ☐ No

☐ HIV positive ☐ AIDS ☐ Diseases associated with AIDS

J. Musculoskeletal Conditions/Disorders: ☐ Yes ☐ No

☐ Arthritis ☐ Gout ☐ Lupus ☐ Herniated disc ☐ Temporomandibular joint disorder (TMJ)
☐ Carpal tunnel syndrome ☐ Disease/disorder of the back or spine ☐ Other bone or joint disorder

K. Mental/Behavioral/Emotional Conditions/Disorders: ☐ Yes ☐ No

☐ Depression ☐ Anxiety disorder ☐ Attention deficit disorder ☐ Chemical imbalance ☐ Bi-polar disorder
☐ Obsessive compulsive disorder ☐ Eating disorder

L. Allergies: ☐ Yes ☐ No

☐ Allergies in any form ☐ Hay fever ☐ Hives ☐ Anaphylaxis

M. Eye Conditions/Disorders: ☐ Yes ☐ No

☐ Glaucoma ☐ Cataracts ☐ Strabismus (crossed eyes) ☐ Detached retina

N. Ear Conditions/Disorders: ☐ Yes ☐ No

☐ Hearing disorder ☐ Ear infection ☐ Loss of hearing

O. Nasal Conditions/Disorders: ☐ Yes ☐ No

☐ Deviated septum ☐ Adenoiditis ☐ Sinusitis

P. Throat Conditions/Disorders: ☐ Yes ☐ No

☐ Tonsillitis ☐ Strep throat

Q. Skin Conditions/Disorders: ☐ Yes ☐ No

☐ Acne ☐ Psoriasis ☐ Eczema ☐ Keratosis ☐ Pre-cancerous lesions ☐ Herpes ☐ Melanoma

R. Congenital Abnormalities/Developmental Disorders: ☐ Yes ☐ No

- **Congenital Abnormality:** ☐ Cleft palate/lip ☐ Club foot ☐ Heart/lung/kidney defect or malformation
- **Developmental Disorder:** ☐ Pervasive development disorder ☐ Down's syndrome ☐ Autism spectrum disorder ☐ Learning disability

S. Reproductive System Conditions/Disorders: ☐ Yes ☐ No

- **Female:** ☐ Infertility ☐ Abnormal menstrual bleeding ☐ Abnormal PAP smear ☐ Endometriosis ☐ Ovarian cyst ☐ Sexually transmitted disease ☐ Human papillomavirus (HPV) ☐ Pregnancy complications ☐ Uterine fibroid ☐ Breast infection or inflammation
- Is any female applicant currently pregnant, an expectant parent, or in the process of adopting? ☐ Yes ☐ No
- **Male:** ☐ Infertility ☐ Erectile dysfunction ☐ Sexually transmitted disease ☐ Prostate disorder ☐ Gynecomastia
- Is any male applicant an expectant parent or in the process of adopting? ☐ Yes ☐ No

T. Other Conditions: ☐ Yes ☐ No

Within the **past 5 years**, has anyone applying for coverage been diagnosed with, had treatment or testing recommended, received treatment, including prescription medications, or been hospitalized for **any illness, injury, or health condition not indicated elsewhere in this application?**

Note: You must include any illness, injury, or health condition related to one of the categories above, even if your specific illness, injury, or condition is not listed above.

PRIMARY APPLICANT NAME ________________________________ DATE ____________________

DEPENDENT NAME (If submitted separately) ____

Within the past FIVE (5) YEARS:		
2 Has anyone applying for coverage received treatment or had treatment recommended for drug or alcohol abuse, or been convicted of a drug or alcohol related offense (including a DUI)?	☐ Yes	☐ No
3 **Other than indicated elsewhere on this application**, has anyone applying for coverage had an implant (e.g., breast, chin, or penile implant), internal fixation (e.g., pins, plates, rods, screws), prosthesis, pacemaker, heart valve replacement, shunt, or monitoring device?	☐ Yes	☐ No
4 Has anyone applying for coverage had testing performed and are currently **waiting for results**, or been advised to have treatment, testing, counseling, therapy, or surgery which has **not yet been performed**?	☐ Yes	☐ No

Within the past TWELVE (12) MONTHS:		
5 Has anyone applying for coverage experienced unexpected weight gain or loss of more than 20 pounds?	☐ Yes	☐ No
6 Has anyone applying for coverage used any tobacco product (such as cigarettes, snuff, chewing tobacco, or any nicotine substitution product)? ▶ If yes, indicate who: ☐ Primary Applicant ☐ Spouse/Domestic Partner ☐ Dependent Children	☐ Yes	☐ No
7 Has anyone applying for coverage participated in any dangerous or extreme sport activities, including, but not limited to: organized automobile/motorcycle/powerboat racing, skydiving, bungee jumping, ultralight flying, scuba diving, hang gliding, or outdoor rock/mountain climbing?	☐ Yes	☐ No

If yes, indicate:

Who & Which Activity	When/How Often	Do you plan continued participation?
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No

8 **Other than indicated elsewhere on this application**, has any person applying for coverage EVER been treated, hospitalized, or had surgery for:

◆ bypass?	☐ Yes	☐ No
◆ angioplasty?	☐ Yes	☐ No
◆ stent?	☐ Yes	☐ No
◆ aneurysm?	☐ Yes	☐ No
◆ valve replacement?	☐ Yes	☐ No
◆ cancer?	☐ Yes	☐ No
◆ stroke?	☐ Yes	☐ No
◆ congenital abnormality?	☐ Yes	☐ No
◆ organ or bone marrow transplant?	☐ Yes	☐ No

PRIMARY APPLICANT NAME ____________________ DATE ______________

DEPENDENT NAME (If submitted separately) ______________________

9 For EACH person applying for coverage, complete the following information regarding his/her **last physical exam** (including checkups):

Self Name:________________ Exam Date (MM/YY):_____/_____ Routine preventive care/wellness visit? ☐ Y ☐ N

Spouse/Domestic Partner's Name: ________________ Exam Date (MM/YY):_____/_____ Routine preventive care/wellness visit? ☐ Y ☐ N

Dependent's Name:________________ Exam Date (MM/YY):_____/_____ Routine preventive care/wellness visit? ☐ Y ☐ N

Dependent's Name:________________ Exam Date (MM/YY):_____/_____ Routine preventive care/wellness visit? ☐ Y ☐ N

Dependent's Name:________________ Exam Date (MM/YY):_____/_____ Routine preventive care/wellness visit? ☐ Y ☐ N

Dependent's Name:________________ Exam Date (MM/YY):_____/_____ Routine preventive care/wellness visit? ☐ Y ☐ N

10 For EACH person applying for coverage, provide the following current information regarding his/her **height and weight**:

Self Name:________________ Height (Feet/Inches):______/______ Weight (in pounds): __________

Spouse/Domestic Partner's Name: ________________ Height (Feet/Inches):______/______ Weight (in pounds): __________

Dependent's Name:________________ Height (Feet/Inches):______/______ Weight (in pounds): __________

Dependent's Name:________________ Height (Feet/Inches):______/______ Weight (in pounds): __________

Dependent's Name:________________ Height (Feet/Inches):______/______ Weight (in pounds): __________

Dependent's Name:________________ Height (Feet/Inches):______/______ Weight (in pounds): __________

F Additional Information

If you answered "YES" to any of the questions in Section E, you must provide additional information below. For an example of how to fill out this section, please visit the Illinois Department of Insurance website at www.insurance.illinois.gov.

Attach a separate sheet for additional information if necessary.

Question Number: _______ **Name of Individual:** ______________________

Condition/Diagnosis: ______________________

Treatment Received: ______________________

____

Treatment ongoing? ☐ Yes ☐ No First & Last Treatment Date: ______________________

Additional tests or treatment recommended? ______________________

Medication Prescribed (if any): ______________________

______________________ Currently taking medication? ☐ Yes ☐ No

Physician Name ______________________

Phone # (______________)______________ City & State ______________________

PRIMARY APPLICANT NAME ____________________ DATE ____________

DEPENDENT NAME (If submitted separately) ____________________

Question Number: _______ Name of Individual: ____________________

Condition/Diagnosis: ____________________

Treatment Received: ____________________

Treatment ongoing? ☐ Yes ☐ No First & Last Treatment Date: ____________________

Additional tests or treatment recommended? ____________________

Medication Prescribed (if any): ____________________

____________________ Currently taking medication? ☐ Yes ☐ No

Physician Name ____________________

Phone # (__________)______________ City & State ____________________

Question Number: _______ Name of Individual: ____________________

Condition/Diagnosis: ____________________

Treatment Received: ____________________

Treatment ongoing? ☐ Yes ☐ No First & Last Treatment Date: ____________________

Additional tests or treatment recommended? ____________________

Medication Prescribed (if any): ____________________

____________________ Currently taking medication? ☐ Yes ☐ No

Physician Name ____________________

Phone # (__________)______________ City & State ____________________

Question Number: _______ Name of Individual: ____________________

Condition/Diagnosis: ____________________

Treatment Received: ____________________

Treatment ongoing? ☐ Yes ☐ No First & Last Treatment Date: ____________________

Additional tests or treatment recommended? ____________________

Medication Prescribed (if any): ____________________

____________________ Currently taking medication? ☐ Yes ☐ No

Physician Name ____________________

Phone # (__________)______________ City & State ____________________

Question Number: _______ Name of Individual: ____________________

Condition/Diagnosis: ____________________

Treatment Received: ____________________

Treatment ongoing? ☐ Yes ☐ No First & Last Treatment Date: ____________________

Additional tests or treatment recommended? ____________________

Medication Prescribed (if any): ____________________

____________________ Currently taking medication? ☐ Yes ☐ No

Physician Name ____________________

Phone # (__________)______________ City & State ____________________

PRIMARY APPLICANT NAME ________________________________ DATE ____________________

DEPENDENT NAME (If submitted separately) ____

G Prescription Information within the Last Twelve (12) Months

Within the past 12 months, has anyone applying for coverage been prescribed medication (other than for the common cold or flu) that is **not indicated elsewhere in this application**? ☐ Yes ☐ No

Attach a separate sheet for additional information if necessary.

Name of Individual: ____

Name of Medication: ____

Reason for Taking: ____

First & Last Treatment Date: ____________________ Currently taking medication? ☐ Yes ☐ No

Physician Name: ____

Phone # (________)____________________ City & State ____________________

Name of Individual: ____

Name of Medication: ____

Reason for Taking: ____

First & Last Treatment Date: ____________________ Currently taking medication? ☐ Yes ☐ No

Physician Name: ____

Phone # (________)____________________ City & State ____________________

Name of Individual: ____

Name of Medication: ____

Reason for Taking: ____

First & Last Treatment Date: ____________________ Currently taking medication? ☐ Yes ☐ No

Physician Name: ____

Phone # (________)____________________ City & State ____________________

Name of Individual: ____

Name of Medication: ____

Reason for Taking: ____

First & Last Treatment Date: ____________________ Currently taking medication? ☐ Yes ☐ No

Physician Name: ____

Phone # (________)____________________ City & State ____________________

Name of Individual: ____

Name of Medication: ____

Reason for Taking: ____

First & Last Treatment Date: ____________________ Currently taking medication? ☐ Yes ☐ No

Physician Name: ____

Phone # (________)____________________ City & State ____________________

PRIMARY APPLICANT NAME ________________________________ DATE ____________________

AFFIRMATION

Signature – Adult applicants must sign this form below. Parent or guardian signature is required for applicants under the age of 18. By signing this form, you certify the following:

1. I have read this entire application or it has been read to me.
2. No independent producer, agent, or employee of the insurer can change any part of this application or waive the requirement that I answer all questions completely and accurately.
3. I understand that if I intentionally omit or provide false information on or in relation to this application, then this policy may be cancelled retroactively, in which case any claim I submit may not be paid by the insurer. I understand that if I intentionally omit or provide false information on or in relation to this application that I may face legal liability, including legal action based on fraud.
4. **All of the answers provided within this application are, to the best of my knowledge and belief, true and complete.** For more information, please visit the Illinois Department of Insurance's website at www.insurance.illinois.gov.

STATEMENT OF UNDERSTANDING

I understand and agree that:

- The information I have provided in this application will be used by the insurer to determine whether to extend coverage and the premium amount for such coverage.
- No coverage shall be in force until approved by the insurer. If approved, coverage will be in force as of the effective date determined by the insurer.
- This application will become part of the contract between the insurer and me.
- Except for a dependent up to the age of 19, coverage for preexisting medical conditions may be excluded or be subject to a waiting period of up to 24 months.
- I am entitled to a copy of this application and the Authorization to Use and Disclose Protected Health Information that is a part of this application upon request. I agree that a photographic copy shall be as valid as the original. A legible facsimile signature shall have the same force and effect as the original.
- I authorize the insurer to transmit the information contained herein electronically.

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

I. Protected Health Information

By signing this form, I authorize certain organizations and persons to use or disclose my protected health information. Protected health information includes, but is not limited to, hospital records, physician records, claim or benefit records, lab results, mental health records, as well as information regarding the use of drug, alcohol, HIV/AIDS, sexually transmitted disease, and reproductive health services. Protected health information may be written, oral, or electronic. This form does not permit the use or disclosure of psychotherapy notes.

II. Purpose of this Authorization Form

By signing this form, I authorize the use and disclosure of protected health information for the purposes of pre-enrollment underwriting or risk-rating of health insurance coverage, to determine eligibility for enrollment or benefits under a health plan, or to allow the insurer to conduct utilization review and quality improvement activities ("Purpose").

III. Entities Authorized to Use and Disclose My Protected Health Information

Insurers: I hereby authorize the following insurers, their reinsurers, and their legal representatives ("Insurers") to receive, use, and disclose my protected health information for the Purpose listed above:

(Please list below the names of all the insurers to whom you are submitting this application).

Insurer: ____________________ Insurer: ____________________ Insurer: ____________________

Insurer: ____________________ Insurer: ____________________ Insurer: ____________________

PRIMARY APPLICANT NAME ________________________________ DATE ____________________

I authorize the Insurers to disclose my protected health information: between themselves, to reinsuring companies, and to insurance intermediaries or other persons or organizations performing business or legal services in connection with the Purpose above.

I further authorize any licensed physician, medical practitioner, health care provider, hospital, clinic, or other medical or medically related facility, insurance or reinsuring company, or other organization, institution, or person that has any record or knowledge of my health to disclose such information to the extent permitted by law to Insurers for the Purpose above.

I understand that protected health information described in this form may be used by, or disclosed to or by, organizations and persons who are not subject to federal or state privacy laws.

IV. Term of Authorization
I agree this Authorization shall be valid for two-and-one-half (2 ½) years from the latest signature date below.

V. Right to Revoke
I understand I may revoke this authorization at any time by giving advance written notice to Insurers. Revocation of this authorization form will not affect actions Insurers and others took in reliance on this form prior to the written notice of revocation.

If this application was taken over the phone or on the computer, I acknowledge that I, myself, have not actually signed this application but instead hereby authorize the insurance carrier to print “Electronically Acknowledged” on the signature line of the application and I agree that such printing shall be treated as a valid signature for all purposes of this form. I acknowledge that the insurance carrier has verified my identity for this purpose in accordance with any applicable law or regulation.

I HAVE READ AND CONSIDERED THE CONTENTS OF THIS FORM. BY SIGNING THIS FORM, I HEREBY AUTHORIZE THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

____ Date ________________
Primary Applicant (or Authorized Legal Representative) Signature

____ Date ________________
Spouse / Domestic Partner Signature (ONLY if to be insured)

____ Date ________________
Dependent Signature (ONLY if 18 or over and ONLY if to be insured)

____ Date ________________
Dependent Signature (ONLY if 18 or over and ONLY if to be insured)

____ Date ________________
Dependent Signature (ONLY if 18 or over and ONLY if to be insured)

____ Date ________________
Dependent Signature (ONLY if 18 or over and ONLY if to be insured)

✪ For assistance in completing this application, please contact your insurance agent or the insurance company directly. For information about your health insurance rights under state and federal law, and other resources, please contact the Illinois Department of Insurance’s Office of Consumer Health Insurance, toll free at (877) 527-9431.

PRIMARY APPLICANT NAME ___________________________________ DATE _______________________

TO BE COMPLETED BY AGENT
I. Agent/Producer Information

I certify that:
1. All answers provided in this application were completed by or provided by the applicant.
2. I have reviewed this enrollment form to ensure that all required items have been completed.
3. I am not aware of any information not disclosed on this enrollment form relating to the health, habits, or reputation of any person listed on this enrollment form, which might have a bearing on the risk.

1. Producer/Writing Agent

Name:	ID#/Code:
Company:	Phone: ( )
Email:	

Producer Signature:
Date Signed:
(A faxed signature shall be valid as an original signature.)

2. Agent/Managing Agent

Name:	ID#/Code:
Company:	Phone: ( )
Email:	

Agent Signature:
Date Signed:
(A faxed signature shall be valid as an original signature.)