



BlueCross BlueShield of Illinois

Experience. Wellness. Everywhere.SM

Traditional BlueSM

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. Traditional Blue Coverage** — Traditional Blue coverage is designed to provide you with economic incentives for

using designated hospitals. It provides, to persons insured, coverage for major Hospital, medical, and surgical expenses incurred as a result of a covered accident or sickness. Coverage is provided for daily Hospital room and board, miscellaneous Hospital services, surgical services, anesthesia services, In-Hospital medical services, and Out-of-Hospital care, subject to any Deductibles, Copayment provisions, or other limitations which may be set forth in the Policy. **Although you can go to the Hospitals of your choice, your benefits under the Traditional Blue plan will be greater when you use the services of participating Hospitals.**

BASIC PROVISIONS	TRADITIONAL BLUE
	Participating Provider Option (PPO) Coverage
Lifetime Benefit	\$5,000,000
<p>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.)</p> <p><i>Carryover Deductible</i> 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.</p>	<p>\$250*</p> <p>\$500*</p> <p>\$1,000*</p> <p>\$2,500*</p> <p>\$5,000*</p>
Family Aggregate Deductible Per family, per calendar year.	Equal to three times the individual Deductible
Hospital Admission Deductible Per admission, per individual.	\$0
<p>Coinsurance The level of coverage provided by the plan after the calendar year Deductible has been satisfied.</p> <p>You must select a level of participating provider coverage:</p> <p>100% participating provider coverage, or</p> <p>80% participating provider coverage</p>	<p>100%</p> <p>-----</p> <p>80%</p>
<p>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 Usual and Customary Fee or the Eligible Charges, and items asterisked (*) <u>do not</u> apply to the out-of-pocket expense limit.</p>	\$1,000
Family Aggregate Out-of-Pocket Expense Limit Equal to three times the individual out-of-pocket limit, per family, per calendar year.	\$3,000

BASIC PROVISIONS	TRADITIONAL BLUE
	Participating Provider Option (PPO) Coverage
Inpatient/Outpatient Physician Medical/Surgical Services	80%
Well-Child Care To age 16. Includes immunizations, physical exams, and routine diagnostic tests. (\$500 per calendar year maximum, per dependent.)	80%
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%
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%
Optional Maternity Coverage <i>When elected, maternity benefits will begin 365 days after the effective date of the maternity coverage.</i> Inpatient/Outpatient Physician Medical/Surgical Services Inpatient/Outpatient Hospital Services	80%
	100%
	----- 80%
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 Of a registered physical, occupational, or speech therapist (\$3,000 per therapy, per calendar year maximum*); naprapathic services rendered by a Naprapath (\$1,000 per calendar year maximum*); ambulance service; durable medical equipment; artificial limbs and other prosthetic devices; oxygen and its administration; blood plasma; private duty nursing services (\$1,000 per month maximum*); Temporomandibular Joint Dysfunction (TMJ) and related disorders (\$1,000 lifetime maximum*); leg, arm, back, and neck braces; surgical; dressing; casts and splints; and outpatient prescription drugs.	80%

BASIC PROVISIONS	TRADITIONAL BLUE
	Participating Provider Option (PPO) Coverage
Mental Illness Treatment and Substance Abuse Rehabilitation Treatment**	
Inpatient Care (30 Inpatient Hospital days per calendar year.)	
Physician	80%*
Hospital	First 14 days Thereafter
	60%* 50%*
Outpatient Care (30 visits per calendar year combined annual maximum and 100 visits per lifetime maximum.)	
Physician and Hospital	50%*
<p>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.*</p>	
<p>Medical Services Advisory (MSA®) The MSA helps you maximize your benefits. The Participating Provider is responsible for notifying MSA when services are rendered at a Participating Hospital. The Policyholder is responsible for notifying MSA for Hospital admissions at Non-PPO and Non-Plan Hospitals. MSA notification is required within three business days for non-emergencies and within one business day for emergencies and maternity admissions. If Policyholder does not notify MSA, Hospital benefits are reduced by \$1,000.*</p>	

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

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

A \$300 per admission Deductible will apply in addition to the individual or family Deductible.*

If You've Selected 100% Participating Provider Coverage...

Hospital benefits shown on the previous pages, which are paid at 100% at Participating Hospitals, are paid at 80% at Non-PPO Hospitals, and 50% at Non-Plan Hospitals, except for Outpatient Emergency Care, and additional surgical opinions which are paid at 100%, regardless of the Hospital selected.

With the exception of alcoholism, there are no benefits for Substance Abuse Rehabilitation Treatment at Non-Plan facilities.

The out-of-pocket expense limit for Non-PPO Hospitals is \$5,000 for individual coverage and \$15,000 for family coverage.

If You've Selected 80% Participating Provider Coverage...

Hospital benefits shown on the previous pages, which are paid at 80% at Participating Hospitals, are paid at 60% at Non-PPO Hospitals, and 50% at Non-Plan Hospitals, except for Outpatient Emergency Care, and additional surgical opinions which are paid at 100% regardless of the Hospital selected.

With the exception of alcoholism, there are no benefits for Substance Abuse Rehabilitation Treatment at Non-Plan facilities.

The out-of-pocket expense limit for Non-PPO Hospitals is \$5,000 for individual coverage and \$15,000 for family coverage.

* 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.

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-44 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-44 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 rendered or provided for the diagnosis and/or treatment of infertility including, but not limited to, Hospital services, Medical Care, therapeutic injection, fertility and other drugs, Surgery, artificial insemination, and all forms of in-vitro fertilization; Maternity Service, including related services and supplies, unless selected as an option (Complications of Pregnancy are covered as any other illness).