BlueCross BlueShield of Illinois

OUR MOST POPULAR
MAJOR MEDICAL PLANS

SelectBlue® & BlueValue®

ALSO AVAILABLE...
NEW LOWER-COST PLANS!

SelectBlue Advantage®
& BlueValue Advantage®

Now Available to Children on an Individual Basis!

INDIVIDUAL AND FAMILY HEALTH INSURANCE

it just fits.

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

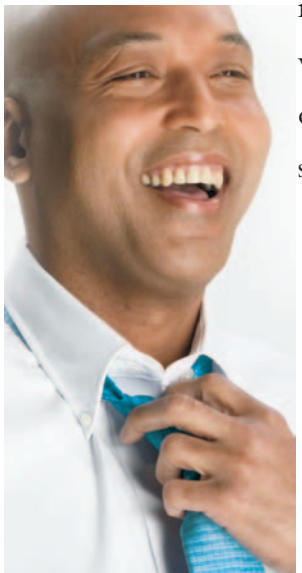
It fits your life…

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!



and your budget!

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!

BlueCross BlueShield of Illinois

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 dependent children under age 19 (age 25 if a single, full-time student). 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

Save as Much as 10%!

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 as much as 10% 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

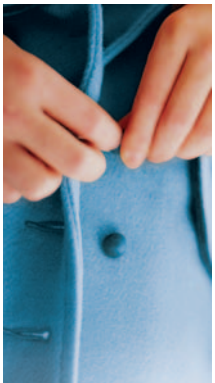
BlueValue offers a choice of a $250, $500, $1,000, $2,500 or $5,000 deductible. Whatever your budget, we have an option for you.

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 dependent children under age 19 (age 25 if a single, full-time student). 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

Save as Much as 10%!

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 as much as 10% on premiums. So if you like the coverage and affordability BlueValue has to offer, but want an even lower premium, consider BlueValue Advantage!

See Why More Than 4 Million Illinois Residents Choose Blue Cross and Blue Shield of Illinois

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.

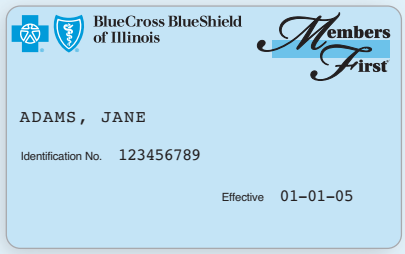
No Paperwork — Your Claims Are Handled for You

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.

Our *Members First*®′ Discount Program

Helps You Save Money on Dental, Vision, Hearing and Chiropractic Care Services!

***Members First*®′ can save you hundreds of dollars a year on products and services you use every day. You'll save on dental, vision, hearing and chiropractic care services. You'll even receive discounts on vitamins and nutritional supplements through mail order.**



Because this isn't insurance, there are no deductibles, no dollar maximum limits and no claim forms to fill out. Using this program costs you nothing extra. It's just our way of saying *"thank you"* for being a member.

- The Dental Program saves you as much as 50% on routine and preventive dental services when you go to one of the many participating providers throughout the entire United States — over 15,000 nationwide. You'll receive your discount at the time of service.
- The Vision Program guarantees savings of as much as 50% on eyeglasses and contact lenses at participating eyecare centers nationwide, including LensCrafters, Sears, JCPenny and Pearle Vision.
- The Hearing Program provides savings on hearing aids and a variety of other products and services from the largest network of audiologists in the U.S. You'll receive a discount of as much as 20% on conventional hearing aids.
- The Chiropractic Program emphasizes wellness and preventive health care at special rates from participating providers. Your initial exam is just $35, and there's no limit on the number of visits. Go to the chiropractor as often as you need for immediate savings of as much as 40% off chiropractic care.
- The Vitamin Program offers a variety of vitamins and nutritional supplements at savings of 25% to 50% off already-low catalog prices.

MEMBERS FIRST: AN EXCLUSIVE PRIVILEGE OF BLUE CROSS AND BLUE SHIELD OF ILLINOIS MEMBERSHIP

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 four million residents across Illinois *Carry the Caring Card*® because they 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" (Excellent) rating.⋆

⋆ As of June 2004

BENEFITS OVERVIEW

SelectBlue & SelectBlue Advantage

COVERAGE AVAILABLE TO INDIVIDUAL ADULTS, INDIVIDUAL CHILDREN

BENEFIT	SelectBlue Participating Provider Coverage[1]	SelectBlue Advantage Participating Provider Coverage[1]
Provider Network	90% of Illinois doctors and more than 200 hospitals	
Lifetime Benefit	$5,000,000	
Individual Deductible	$0, $250, $500, $1,000, $2,500 or $5,000[2]	$250, $500, $1,000, $1,750, $2,500 or $5,000[2]
Individual Out-of-Pocket Expense Limit	$1,000	$3,000
Office Visits and Outpatient Physician Services	100% after you pay $20 copay[2,3] per visit (Deductible does not apply)	100% after you pay $30 copay[2,3] per visit (Deductible does not apply)
Hospital Services		
• ***Inpatient Physician Services***	100% or 80%	80%
• ***Outpatient Services*** Includes surgery and pre-admission testing	100% or 80%	80%
• ***Inpatient Services*** Includes semi-private room and board, pre-admission testing, prescription drugs and more	100% or 80%	80%
• ***Inpatient/Outpatient Diagnostic Testing*** Includes X-rays, lab tests, EKGs, ECGs, pathology services, pulmonary function studies and more	100% or 80%	80%
Well-Adult 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)	100% after you pay $20 copay[2] per visit (Deductible does not apply)	100% after you pay $30 copay[2] per visit (Deductible does not apply)
Well-Child Care To age 16. Includes immunizations, physical exams and routine diagnostic tests. ($500 per calendar year maximum)	100% after you pay $20 copay[2] per visit (Deductible does not apply)	100% after you pay $30 copay[2] per visit (Deductible does not apply)
Outpatient Emergency Care Includes covered services received in a hospital or a physician's office	100% (Deductible does not apply)	80% after $75 copayment per visit (Deductible does not apply)
Physical, Occupational or Speech Therapist ($3,000 per therapy, per calendar year maximum)	100% or 80%[2]	80%[2]

BENEFIT	SelectBlue Participating Provider Coverage[1]	SelectBlue Advantage Participating Provider Coverage[1]
Outpatient Prescription Drugs	**$0[4], $250 and $500 Deductible plans ONLY** • Generic . . . . . .100% (after $10 copayment) • Brand formulary . . . . . .65%[2] • Brand non-formulary . . . . . .50%[2] Home delivery: Up to a 90-day supply of maintenance drugs is available through home delivery and is subject to a $300 maximum per prescription **$1,000, $1,750[5], $2,500 and $5,000 Deductible plans ONLY** Covered at 80% after your deductible	
Mental Illness Treatment and Substance Abuse Rehabilitation Treatment[6] ***Inpatient Care*** (30 Inpatient Hospital days per calendar year) • Physician	100% or 80%[2]	80%[2]
• Hospital — First 14 days	60%[2]	
Thereafter	50%[2]	
Outpatient Care (30 visits per calendar year combined annual maximum and 100 visits per lifetime maximum) • Physician and Hospital	50%[2]	
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% or 80%	80%

[1] Benefits are reduced when non-participating providers are used.

[2] Does not apply to out-of-pocket expense limit.

[3] Services not billed as part of the office visit by your physician on the same day are subject to your deductible and coinsurance. These might include, but are not limited to outpatient lab tests. Outpatient surgery, therapy and certain diagnostic services (including MRI, CT scan, pulmonary function studies, cardiac catheterization, EEG, EKG, ECG and swan ganz catheterization) are not covered by the copayment and instead are covered subject to the plan's deductible and coinsurance.

[4] SelectBlue only

[5] SelectBlue Advantage only

[6] 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.

Maximizing Your Benefits Can Be Just a Phone Call Away!

Blue Cross and Blue Shield of Illinois wants to make sure you get the maximum coverage and the most appropriate care. That's why our health insurance plans include the services of two units of health professionals. They're called the Mental Health Unit and the Medical Services Advisory (MSA®). By calling one of these units whenever you need mental health and substance abuse services, or if you find yourself receiving treatment at an out-of-network hospital, you're assured of maximum benefits and the very best health care.

BENEFITS OVERVIEW

BlueValue & BlueValue Advantage

COVERAGE AVAILABLE TO INDIVIDUAL ADULTS, INDIVIDUAL CHILDREN

BENEFIT	BlueValue Participating Provider Coverage[1]	BlueValue Advantage Participating Provider Coverage[1]
Provider Network	90% of Illinois doctors and more than 200 hospitals	
Lifetime Benefit	$5,000,000	
Individual Deductible	$250, $500, $1,000, $2,500 or $5,000[2]	$250, $500, $1,000, $1,750 $2,500 or $5,000[2]
Individual Out-of-Pocket Expense Limit	$1,000	$3,000
Office Visits and Outpatient Physician Services	100% or 80%	80%
Hospital Services		
• ***Inpatient Physician Services***	100% or 80%	80%
• ***Outpatient Services*** Includes surgery and pre-admission testing	100% or 80%	80%
• ***Inpatient Services*** Includes semi-private room and board, pre-admission testing, prescription drugs and more	100% or 80%	80%
• ***Inpatient/Outpatient Diagnostic Testing*** Includes X-rays, lab tests, EKGs, ECGs, pathology services, pulmonary function studies and more	100% or 80%	80%
Well-Child Care To age 16. Includes immunizations, physical exams and routine diagnostic tests. ($500 per calendar year maximum)	100% or 80%	80%
Outpatient Emergency Care Includes covered services received in a hospital or a physician's office	100% (Deductible does not apply)	80% after $75 copayment per visit (Deductible does not apply)
Physical, Occupational or Speech Therapist ($3,000 per therapy, per calendar year maximum)	100% or 80%[2]	80%[2]

BENEFIT	BlueValue Participating Provider Coverage[1]	BlueValue Advantage Participating Provider Coverage[1]
Outpatient Prescription Drugs	80%	
Mental Illness Treatment and Substance Abuse Rehabilitation Treatment[3]		
Inpatient Care		
(30 Inpatient Hospital days per calendar year)		
• Physician	100% or 80%[2]	80%[2]
• Hospital — First 14 days	60%[2]	
Thereafter	50%[2]	
Outpatient Care		
(30 visits per calendar year combined annual maximum and 100 visits per lifetime maximum)		
• Physician and Hospital	50%[2]	
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% or 80%	80%

[1] Benefits are reduced when non-participating providers are used.

[2] Does not apply to out-of-pocket expense limit.

[3] 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.

Maximizing Your Benefits Can Be Just a Phone Call Away!

Blue Cross and Blue Shield of Illinois wants to make sure you get the maximum coverage and the most appropriate care. That's why our health insurance plans include the services of two units of health professionals. They're called the Mental Health Unit and the Medical Services Advisory (MSA®). By calling one of these units whenever you need mental health and substance abuse services, or if you find yourself receiving treatment at an out-of-network hospital, you're assured of maximum benefits and the very best health care.

BlueCross BlueShield of Illinois

(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, preliminary 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; durable medical equipment; services of a private duty nursing service ($1,000 per month maximum★); naprapathic services rendered by a Naprapath ($1,000 per calendar year maximum★); artificial limbs and other prosthetic devices; oxygen and its administration; blood plasma; leg, arm and neck braces; surgical dressings; casts and splints.	80%	
Mental Illness Treatment and Substance Abuse Rehabilitation Treatment		
Inpatient Care (30 Inpatient Hospital days per calendar year.)	100%	80%★
Physician	80%★	60%★
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 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††
$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, $1,750, $2,500 and $5,000 Deductible plans ONLY (Subject to deductible and coinsurance.)	20%	80%

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

★ *Does not apply to out-of-pocket expense limit.*
† *Deductible does not apply.*
†† *Benefits will be significantly reduced if you use a non-participating pharmacy.*

IF USING A NON-PLAN PROVIDER...

A $300 per Hospital admission Deductible will apply.* If using a Non-Plan Provider, benefits are reduced to 50%. 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 non-payment of premium. Blue Cross and Blue Shield can refuse to renew this Policy only for the following reasons:

A. If all Policies bearing form number DB-43 HCSC are not renewed, written notice will be provided at least 90 days before coverage is discontinued. Furthermore, you may convert to any other individual policy Blue Cross and Blue Shield offers to the individual market.

B. In the event of fraud or an intentional misrepresentation of material fact under the terms of the coverage, written notice will be given at least 30 days before coverage is discontinued.

Exclusions and Limitations:

Hospitalization, Services, and supplies which are not Medically Necessary; Services or supplies that are not specifically mentioned in this Policy; Services or supplies for any illness or injury arising out of or in the course of employment for which benefits are available under any Workers' Compensation Law or other similar laws whether or not you make a claim for such compensation or receive such benefits except where not required by law; Services or supplies that are furnished to you by the local, state, or federal government; Services and supplies for any illness or injury occurring on or after your Coverage Date as a result of war or an act of war; Services or supplies that do not meet accepted standards of medical or dental practice; Investigational Services and Supplies, including all related services and supplies; Custodial Care Service; Routine physical examinations, unless specifically stated in this Policy; Services or supplies received during an Inpatient stay when the stay is primarily related to behavioral, social maladjustment, lack of discipline, or other antisocial actions which are not specifically the result of Mental Illness; Cosmetic Surgery and related services and supplies, except for the correction of congenital deformities or for conditions resulting from accidental injuries, scars, tumors, or diseases; Services or supplies for which you are not required to make payment or would have no legal obligation to pay if you did not have this or similar coverage; Charges for failure to keep a scheduled visit or charges for completion of a Claim form; Personal hygiene, comfort, or convenience items commonly used for other than medical purposes, such as air conditioners, humidifiers, physical fitness equipment, televisions, and telephones; Special braces, splints, specialized equipment, appliances, ambulatory apparatus, battery controlled implants, except as specifically mentioned in this Policy; Eyeglasses, contact lenses, or cataract lenses and the examinations for prescribing or fitting of glasses or contact lenses or for determining the refractive state of the eye, except as specifically mentioned in this Policy; Treatment of flat foot conditions and the prescription of supportive devices for such conditions and the treatment of subluxations of the foot or routine foot care; Immunizations, unless otherwise stated in this Policy; Maintenance Occupational Therapy, Maintenance Physical Therapy, and Maintenance Speech Therapy; Speech Therapy when rendered for the treatment of psychosocial speech delay, behavioral problems (including impulsive behavior and impulsivity syndrome), attention disorder, conceptual handicap, or mental retardation; Hearing aids or examinations for the prescription or fitting of hearing aids; Diagnostic Service as part of routine physical examinations or check-ups, premarital examinations, determination of the refractive errors of the eyes, auditory problems, surveys, casefinding, research studies, screening, or similar procedures and studies, or tests which are Investigational, unless otherwise specified in this Policy; Procurement or use of prosthetic devices, special appliances, and surgical implants which are for cosmetic purposes, or unrelated to the treatment of a disease or injury; Services and supplies provided for the diagnosis and/or treatment of infertility including, but not limited to, Hospital services, Medical Care, therapeutic injection, fertility and other drugs, Surgery, artificial insemination, and all forms of in-vitro fertilization; Maternity Service, including related services and supplies, unless selected as an option (Complications of Pregnancy are covered as any other illness); Long Term Care; Inpatient Private Duty Nursing Service; Maintenance Care; Wigs (also referred to as cranial prothesis); 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

CONSUMER MARKETS

BlueCross BlueShield of Illinois

(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, preliminary 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; durable medical equipment; services of a private duty nursing service ($1,000 per month maximum★); naprapathic services rendered by a Naprapath ($1,000 per calendar year maximum★); artificial limbs and other prosthetic devices; oxygen and its administration; blood plasma; leg, arm and neck braces; surgical dressings; casts and splints.	80%	
Mental Illness Treatment and Substance Abuse Rehabilitation Treatment		
Inpatient Care (30 Inpatient Hospital days per calendar year.)		
Physician	80%★	50%★
Hospital First 14 days	60%★	50%★
Thereafter	50%★	50%★
Outpatient Care (30 visits per calendar year combined annual maximum and 100 visits per lifetime maximum.)		
Physician and Hospital	50%★	50%★
Medical Services Advisory (MSA®) In order to maximize your benefits, the Policyholder is responsible for notifying the MSA for Hospital admissions at 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.

★ *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 non-payment of premium. Blue Cross and Blue Shield can refuse to renew this Policy only for the following reasons:

A. If all Policies bearing form number DB-48 HCSC are not renewed, written notice will be provided at least 90 days before coverage is discontinued. Furthermore, you may convert to any other individual policy Blue Cross and Blue Shield offers to the individual market.

B. In the event of fraud or an intentional misrepresentation of material fact under the terms of the coverage, written notice will be given at least 30 days before coverage is discontinued.

Exclusions and Limitations:

Hospitalization, Services, and supplies which are not Medically Necessary; Services or supplies that are not specifically mentioned in this Policy; Services or supplies for any illness or injury arising out of or in the course of employment for which benefits are available under any Workers' Compensation Law or other similar laws whether or not you make a claim for such compensation or receive such benefits except where not required by law; Services or supplies that are furnished to you by the local, state, or federal government; Services and supplies for any illness or injury occurring on or after your Coverage Date as a result of war or an act of war; Services or supplies that do not meet accepted standards of medical or dental practice; Investigational Services and Supplies, including all related services and supplies; Custodial Care Service; Routine physical examinations, unless specifically stated in this Policy; Services or supplies received during an Inpatient stay when the stay is primarily related to behavioral, social maladjustment, lack of discipline, or other antisocial actions which are not specifically the result of Mental Illness; Cosmetic Surgery and related services and supplies, except for the correction of congenital deformities or for conditions resulting from accidental injuries, scars, tumors, or diseases; Services or supplies for which you are not required to make payment or would have no legal obligation to pay if you did not have this or similar coverage; Charges for failure to keep a scheduled visit or charges for completion of a Claim form; Personal hygiene, comfort, or convenience items commonly used for other than medical purposes, such as air conditioners, humidifiers, physical fitness equipment, televisions, and telephones; Special braces, splints, specialized equipment, appliances, ambulatory apparatus, battery controlled implants, except as specifically mentioned in this Policy; Eyeglasses, contact lenses, or cataract lenses and the examinations for prescribing or fitting of glasses or contact lenses or for determining the refractive state of the eye, except as specifically mentioned in this Policy; Treatment of flat foot conditions and the prescription of supportive devices for such conditions and the treatment of subluxations of the foot or routine foot care; Immunizations, unless otherwise stated in this Policy; Maintenance Occupational Therapy, Maintenance Physical Therapy, and Maintenance Speech Therapy; Speech Therapy when rendered for the treatment of psychosocial speech delay, behavioral problems (including impulsive behavior and impulsivity syndrome), attention disorder, conceptual handicap, or mental retardation; Hearing aids or examinations for the prescription or fitting of hearing aids; Diagnostic Service as part of routine physical examinations or check-ups, premarital examinations, determination of the refractive errors of the eyes, auditory problems, surveys, casefinding, research studies, screening, or similar procedures and studies, or tests which are Investigational, unless otherwise specified in this Policy; Procurement or use of prosthetic devices, special appliances, and surgical implants which are for cosmetic purposes, or unrelated to the treatment of a disease or injury; Services and supplies provided for the diagnosis and/or treatment of infertility including, but not limited to, Hospital services, Medical Care, therapeutic injection, fertility and other drugs, Surgery, artificial insemination, and all forms of in-vitro fertilization; Maternity Service, including related services and supplies, unless selected as an option (Complications of Pregnancy are covered as any other illness). Long Term Care; Inpatient Private Duty Nursing Service; Maintenance Care; Wigs (also referred to as cranial prosthesis); and Services and supplies rendered or provided for human organ or tissue transplants other than those specifically named in this Policy.

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

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

CONSUMER MARKETS

(POLICY DB-42 HCSC)

BlueCross BlueShield of Illinois

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; durable medical equipment; services of a private duty nursing service ($1,000 per month maximum★); naprapathic services rendered by a Naprapath ($1,000 per calendar year maximum★); artificial limbs and other prosthetic devices; oxygen and its administration; blood plasma; leg, arm and neck braces; surgical dressings; casts and splints; 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%*
	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.

* *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 non-payment of premium. Blue Cross and Blue Shield can refuse to renew this Policy only for the following reasons:

A. If all Policies bearing form number DB-42 HCSC are not renewed, written notice will be provided at least 90 days before coverage is discontinued. Furthermore, you may convert to any other individual policy Blue Cross and Blue Shield offers to the individual market.

B. In the event of fraud or an intentional misrepresentation of material fact under the terms of the coverage, written notice will be given at least 30 days before coverage is discontinued.

Exclusions and Limitations:

Hospitalization, Services, and supplies which are not Medically Necessary; Services or supplies that are not specifically mentioned in this Policy; Services or supplies for any illness or injury arising out of or in the course of employment for which benefits are available under any Workers' Compensation Law or other similar laws whether or not you make a claim for such compensation or receive such benefits; Services or supplies that are furnished to you by the local, state, or federal government; Services 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

CONSUMER MARKETS

(POLICY DB-49 HCSC)

BlueCross BlueShield of Illinois

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; durable medical equipment; services of a private duty nursing service ($1,000 per month maximum★); naprapathic services rendered by a Naprapath ($1,000 per calendar year maximum★); artificial limbs and other prosthetic devices; oxygen and its administration; blood plasma; leg, arm and neck braces; surgical dressings; casts and splints; 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%★
	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.

★ *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 non-payment of premium. Blue Cross and Blue Shield can refuse to renew this Policy only for the following reasons:

A. If all Policies bearing form number DB-49 HCSC are not renewed, written notice will be provided at least 90 days before coverage is discontinued. Furthermore, you may convert to any other individual policy Blue Cross and Blue Shield offers to the individual market.

B. In the event of fraud or an intentional misrepresentation of material fact under the terms of the coverage, written notice will be given at least 30 days before coverage is discontinued.

Exclusions and Limitations:

Hospitalization, Services, and supplies which are not Medically Necessary; Services or supplies that are not specifically mentioned in this Policy; Services or supplies for any illness or injury arising out of or in the course of employment for which benefits are available under any Workers' Compensation Law or other similar laws whether or not you make a claim for such compensation or receive such benefits; Services or supplies that are furnished to you by the local, state, or federal government; Services 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

CONSUMER MARKETS

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APPLICATION FOR INDIVIDUAL COVERAGE

BlueCross BlueShield of Illinois

To help us process your application promptly, please remember to:

- Print all answers in **black ink**. Pencil will not be accepted.
- Make sure you personally sign the application as the Primary Applicant. If your spouse or any dependent(s) age 18 or over is also applying for coverage, have him/her personally sign the appropriate signature line.
- If it is necessary to correct any errors, simply cross off what is incorrect and write your initials next to the correct information. Please do not use correction fluid.

HOME OFFICE USE ONLY

PART ONE

Check one: ☐ New Policy ☐ Add Dependent ☐ Upgrade (increase of benefits)

SECTION A — PERSON(S) APPLYING FOR COVERAGE (please print)

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.

PRIMARY APPLICANT

First Name, Middle Initial, Last Name	Social Security # – –	Sex (m/f)	Age	Date of Birth (mo./day/yr.) / /	Height (ft., in.)	Weight (lbs.)

Home Phone # ( )	Business Phone # ( )	Fax # (*if available*) ( )	Occupation/Duties	Spouse's Business Phone # (*if applying*) ( )

Residence Street Address	City / State / ZIP	County

Email (*if available*)	Best place and time to call (*if necessary*) ❑ Home ❑ Business ❑ Morning ❑ Afternoon

SPOUSE and DEPENDENT CHILDREN YOU WISH TO COVER (dependent children must be under age 19, or under age 25 if unmarried, full-time student)

NAME: First M.I. Last	RELATION (spouse or child)	SEX	HEIGHT (ft., in.)	WEIGHT (lbs.)	DATE OF BIRTH (mo/day/yr)	SOCIAL SECURITY NUMBER	FULL-TIME STUDENT
		❑ M ❑ F			/ /	– –	❑ Yes ❑ No
		❑ M ❑ F			/ /	– –	❑ Yes ❑ No
		❑ M ❑ F			/ /	– –	❑ Yes ❑ No
		❑ M ❑ F			/ /	– –	❑ Yes ❑ No
		❑ M ❑ F			/ /	– –	❑ Yes ❑ No

SECTION B — COVERAGE APPLIED FOR (please choose only one plan)

☐ **SelectBlue®**
Deductible: ☐ $0 ☐ $250 ☐ $500 ☐ $1,000 ☐ $2,500 ☐ $5,000
Level of Coverage: ☐ 100% ☐ 80%
Do You Want Maternity Coverage? ☐ Yes

☐ **SelectBlue Advantage®**
Deductible: ☐ $250 ☐ $500 ☐ $1,000 ☐ $1,750 ☐ $2,500 ☐ $5,000
Level of Coverage: 80%
Do You Want Maternity Coverage? ☐ Yes

☐ **BlueValue®**
Deductible: ☐ $250 ☐ $500 ☐ $1,000 ☐ $2,500 ☐ $5,000
Level of Coverage: ☐ 100% ☐ 80%
Do You Want Maternity Coverage? ☐ Yes

☐ **BlueValue Advantage®**
Deductible: ☐ $250 ☐ $500 ☐ $1,000 ☐ $1,750 ☐ $2,500 ☐ $5,000
Level of Coverage: 80%
Do You Want Maternity Coverage? ☐ Yes

SECTION C — BILLING INFORMATION

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

REQUESTED EFFECTIVE DATE (mo./day/yr.) _____ **PREMIUM AMOUNT ENCLOSED $** _____

PREMIUM MODE: ☐ Monthly Bank Draft (Submit Authorization form with application, along with a copy of voided check or deposit slip)
☐ Two-Month Direct Bill

Billing Name and Address (if different than name and residence address given above)

PART TWO — EVIDENCE OF INSURABILITY

All health history/medical questions must be completed for all individuals (including dependents) applying for coverage.

SECTION A — HEALTH HISTORY / MEDICAL QUESTIONS

If you answer "Yes" to ANY questions on this page, please give complete details on the next page. Please note the timeframe reference for each question.

1. Has any person applying for coverage been advised to seek treatment for alcohol use or been counseled for, diagnosed with, or treated for alcohol use or abuse, alcohol dependency or alcoholism **within the last 10 years?** ☐ Yes ☐ No

2. Has any person applying for coverage used illegal drugs or substances or been counseled for, diagnosed with, or treated for drug or chemical use or dependency **within the last 10 years?** ☐ Yes ☐ No

3. **Has any person applying for coverage been advised, counseled, tested, diagnosed, treated, hospitalized or recommended for treatment within the last 10 years for the following: Please check ☑ Yes or ☑ No.** ***If any boxes are checked "Yes" (☑ Yes), also circle the condition, e.g. migraines, and give details on the next page.***

   A. Migraines; headaches; carpal tunnel syndrome; seizure disorder; paralysis; multiple sclerosis; any neurological disorder, or any disorder of the central nervous system? ☐ Yes ☐ No

   B. Attention deficit disorder; anxiety, depression or chemical imbalance; any behavioral, emotional or eating disorder; mental retardation; bipolar disorder or psychosis; psychotherapy; marital or any form of counseling or therapy? ☐ Yes ☐ No

   C. Chest pain or palpitations; heart murmur; mitral valve prolapse; heart attack, stroke or TIA, any other heart or circulatory disorder or condition, or hypertension/high blood pressure (HBP)? ☐ Yes ☐ No
   If "Yes" to HBP, provide 3 readings and their dates w/in the last year
   _____ *and* _____ *and* _____

   D. Varicose veins/spider veins/varicosities; elevated cholesterol or lipids; anemia; blood clot or any other blood disorder? ☐ Yes ☐ No

   E. Asthma; allergies; sinusitis; bronchitis; pneumonia; tuberculosis; apnea; chronic obstructive pulmonary disease (COPD); emphysema; or any breathing difficulty, lung or respiratory disease, disorder or condition? ☐ Yes ☐ No

   F. Hernia; colitis; chronic diarrhea or intestinal problems; hemorrhoids or rectal disorder; gastroesophageal reflux; any disorder of the esophagus; ulcer of the stomach or duodenum, or any other digestive disorder or condition? ☐ Yes ☐ No

   G. Any disease or disorder of the gallbladder, pancreas or liver; elevated liver function tests; cirrhosis; hepatitis? *(indicate type of hepatitis*) ☐ Yes ☐ No

   H. Cancer; tumor; growth; cyst; polyp; enlarged lymph nodes; leukemia? *(indicate diagnosis and location*) ☐ Yes ☐ No

   I. Acne; keratosis; psoriasis; basal cell carcinoma; lesions of the skin or mouth, or any other skin disorder? ☐ Yes ☐ No

   J. Kidney stones; reflux; urinary incontinence or any infection or disorder of the urinary tract, bladder or kidney? ☐ Yes ☐ No

   K. Breast cyst or nodule; gynecomastia; fibrocystic breast disease; breast implants, or any other disease or disorder of the breast? ☐ Yes ☐ No

   L. Arthritis (osteo, rheumatoid, psoriatic); bursitis; herniated, bulging or slipped disc; gout; temporomandibular joint syndrome (TMJ); any injury to, disease or disorder of the spine, back, knees, jaw, bones, muscles, or joints; bunions; joint replacement; or manipulation therapy? ☐ Yes ☐ No

   M. Thyroid disorder; goiter; Graves disease; diabetes; lupus; pituitary or adrenal disorder? ☐ Yes ☐ No

   N. Cataracts; glaucoma; hearing loss; deviated nasal septum; or any eye, ear, nose or throat disorder? ☐ Yes ☐ No

   O. Acquired Immune Deficiency Syndrome (AIDS); AIDS-Related Complex (ARC); HIV positive or other immune disorders? ☐ Yes ☐ No

   P. *Question for Male Applicants and Dependents Only*
   Prostate disorder; elevated prostate specific antigen (PSA); sexually transmitted disease; genital warts; herpes; impotence; infertility or any other disease or disorder of the genital or reproductive system? ☐ Yes ☐ No

   Q. *Question for Female Applicants and Dependents Only*
   Fibroid or uterine tumor; ovarian cyst; endometriosis; cystocele/rectocele; abnormal pap smear; infertility; sexually transmitted disease; genital warts; herpes; or any other disease or disorder of the genital or reproductive system? ☐ Yes ☐ No

QUESTION CONTINUES AT RIGHT

4. **During the last 5 years,** has any person applying for coverage had a physical examination (including check-ups), diagnostic tests, consulted a physician, chiropractor or therapist? ☐ Yes ☐ No

5. Has any person applying for coverage been prescribed or taken any medication due to any sickness, disease, disorder, condition, injury or counseling or for smoking cessation or weight loss **in the last 12 months?** ☐ Yes ☐ No

6. Have you or your spouse (if to be insured) smoked or used any tobacco products – such as cigarettes, pipes, cigars, snuff or chewing tobacco – **in the last 12 months?**
   YOU ☐ Yes ☐ No
   YOUR SPOUSE ☐ Yes ☐ No

7. A. *Question for Female Applicants and Dependents Only:* Is any female applying for coverage now pregnant? ☐ Yes ☐ No
   B. *Question for Male Applicants and Dependents Only:* Is any male applying for coverage now an expectant parent? ☐ Yes ☐ No
   If "Yes" to either question, coverage cannot be offered.

8. Does any person applying for coverage **have or ever had** an implant (e.g. breast, chin or penile implant), internal fixation (e.g. pins, plates or screws), prosthesis, pacemaker, valve replacement, shunt or monitoring device? ☐ Yes ☐ No

9. Has any person applying for coverage discussed or been advised to have treatment, testing, counseling, therapy, or surgery **which has not yet been performed?** ☐ Yes ☐ No

10. Has any person applying for coverage **ever** been hospitalized or been treated in the emergency room or had any physical impairment, deformity, congenital anomaly, sickness, operation, injury or hospitalization **other than** admitted to on this page? ☐ Yes ☐ No

PART TWO — CONTINUED

SECTION B — DETAILS OF HEALTH HISTORY

If you answered "Yes" to ANY questions on the previous page, please provide further information using the chart below. Be sure to use the "correct" example as your guide. (If more space is needed, attach a separate page which must be signed and dated.)

	Question Number	Person Affected	Condition, Injury, Symptom, or Diagnosis			Was Recovery Complete?	Types of Treatment, Advice Given, and Medications Prescribed	Name, Address and Phone Number of Doctors and Hospitals
			What is it?	Date that it Started	Date of Recovery (if applicable)			
Incorrect Example:	~~C~~	~~Mr. Smith~~	~~blood pressure~~	~~1995~~	~~N/A~~	~~N/A~~	~~prescription~~	~~Dr. Jones St. Mary's Hospital~~
Correct Example:	3C	Joe Smith	high blood pressure	6/95	none	no, ongoing	40mg Atenolol once a day 140/80 - 7/8/01 138/78 - 10/12/01 139/77 - 2/9/02	Dr. Jones St. Mary's Peoria, IL (309) 555-1212

If one or more family member(s) is ineligible for coverage, would you consider coverage for the remaining family member(s)?..... ☐ Yes ☐ No

SECTION C — OTHER INSURANCE INFORMATION

1. Does any person applying for coverage currently have, or did they previously have, Blue Cross and Blue Shield of Illinois coverage, either as a primary insured or as a dependent? ☐ **Yes** ☐ **No** *If "Yes", please complete the following:*

Member Name _____ Member No. _____ Group No. _____

2. Does any person to be covered have any Major Medical, HMO, or PPO Medical Insurance with any other Insurer? ☐ **Yes** ☐ **No**

3. Will the issuance of this coverage cause you to discontinue your existing coverage? ☐ **Yes** ☐ **No**

If "Yes", when is coverage to be discontinued (mo./day/yr.)? ____/____/____ (Note: A Notice of Replacement Form must also be submitted with your application, even if replacing Blue Cross and Blue Shield of Illinois coverage.)

If "No", please explain _____

4. Has any person applying for coverage ever been declined, postponed, charged an extra premium for or had a rider applied to life, health, or disability insurance, or had any such insurance rescinded? ☐ **Yes** ☐ **No**

If "Yes", please explain _____

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

PART THREE

SECTION A — REPRESENTATIONS, ACKNOWLEDGEMENTS, AND AUTHORIZATIONS

I apply for coverage as indicated in PART ONE, for which I am or may become eligible under the agreement with Health Care Service Corporation (providing hospital and medical coverage) which is herein called the Company. **I have read all the statements in PARTS ONE and TWO, and represent that they are true and complete to the best of my knowledge and belief. I understand that failure to disclose information on PARTS ONE and TWO of this application may be the basis for future claim denial, rescission or reformation as of the original effective date, solely at the discretion of the Company.**

I have read and understand the Outline of Coverage that has been provided to me by my agent who sells Blue Cross and Blue Shield of Illinois insurance plans. My agent has informed me of the provisions of the Blue Cross and Blue Shield of Illinois health plan and the Medical Services Advisory (MSA®´) Program (along with the provisions of the Mental Health Unit if applicable).

I understand that the insurance plan applied for is **not** an employer-sponsored group health plan and it **does not** comply with state or federal small employer laws.

Medical Authorization: I authorize any medical professional, hospital, clinic, pharmacy, pharmacy benefits manager or other pharmacy-related services organization, health plan, or other medical or medically related facility, governmental agency or other person or firm, to disclose to the Company or their authorized representative, information, including copies of records, concerning advice, care or treatment provided to me and/or my dependents, including without limitation, information relating to the use of drugs or alcohol. I also authorize the release of information relating to mental illness. In addition, I authorize the Company to review and research its own records for information.

I understand my authorization is voluntary and that such information will be used by the Company for the purpose of evaluating my application for health insurance. Further, I understand that my authorization is required for the Company to consider my application and to determine whether or not an offer of coverage will be made. No action will be taken on my application without my signed authorization. I understand information obtained with my authorization may be re-disclosed by the Company as permitted or required by law and no longer protected by the federal privacy laws.

I understand that I or any authorized representative will receive a copy of this authorization upon request. This authorization is valid from the date signed and, provided the Company approves coverage, until a policy is put in force unless revoked by me in writing, which I may do at any time. Any revocation will not affect the activities of the Company prior to the date such revocation is received by the Company.

IMPORTANT: Your application must be signed and dated by all applicants as required. (This includes your spouse and all dependents age 18 or over who are applying for coverage.) Missing signatures or dates will cause a delay in processing.

Primary Applicant's Signature: X _____ **Date Signed:** ____/____/____ (mo. / day / yr.)

Spouse's Signature (ONLY if to be insured): X _____ **Date Signed:** ____/____/____ (mo. / day / yr.)

Parent/Guardian Signature (If Primary Applicant is UNDER the age of 18): X _____ **Date Signed:** ____/____/____ (mo. / day / yr.)

Dependent's Signature (ONLY if 18 or over and ONLY if to be insured): X _____ **Date Signed:** ____/____/____ (mo. / day / yr.)

Dependent's Signature (ONLY if 18 or over and ONLY if to be insured): X _____ **Date Signed:** ____/____/____ (mo. / day / yr.)

Dependent's Signature (ONLY if 18 or over and ONLY if to be insured): X _____ **Date Signed:** ____/____/____ (mo. / day / yr.)

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's Signature: X _____

Print Your Name as You Signed It: _____ **Date Signed:** ____/____/____ (mo. / day / yr.)

SECTION B — AGENT STATEMENT

I have personally, completely and accurately reaffirmed the information supplied by the applicant(s).

Agent's Signature: X _____ **Date Signed:** ____/____/____ (mo. / day / yr.)

Print Your Name as You Signed It: _____ **Agent's Phone Number:** (____) _____

Agent's Code: _____

NOTICE TO APPLICANT

Regarding Replacement of Health Insurance

According to information you have furnished, you intend to lapse or otherwise terminate existing health insurance and replace it with a policy to be issued by Health Care Service Corporation. 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, which may be referred to in the policy as pre-existing conditions, may not be immediately or fully covered under this new policy. This could result in denial or delay of a claim for benefits under this 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 interest 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 COMPANY TO DENY 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, reread it carefully to be certain that all information has been properly recorded.

OB1935 Rev. 7/94

NOTE TO PRODUCER: An applicant who is replacing existing health insurance with Blue Cross and Blue Shield coverage must read, sign, and date the blue replacement form at right. You must then submit that replacement form along with the application. This form must remain with the applicant.

NOTICE TO APPLICANT

Regarding Replacement of Health Insurance

According to information you have furnished, you intend to lapse or otherwise terminate existing health insurance and replace it with a policy to be issued by Health Care Service Corporation. 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, which may be referred to in the policy as pre-existing conditions, may not be immediately or fully covered under this new policy. This could result in denial or delay of a claim for benefits under this 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 interest 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 COMPANY TO DENY 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, reread it carefully to be certain that all information has been properly recorded.

The above "Notice to Applicant" was delivered to me on:

_____
Date

_____
Applicant's Signature

OB1935 Rev. 7/94

This form must be signed
and dated by
the applicant and returned
with the application.

This form stays
with the applicant.

CONDITIONAL RECEIPT FOR

BlueCross BlueShield of Illinois
CONSUMER MARKETS

Proposed Insured: _____

Date of Application: _____ Amount Received: _____ Date of Receipt: _____

NO INSURANCE WILL BECOME EFFECTIVE UNLESS EACH AND EVERY CONDITION CONTAINED IN THIS RECEIPT IS MET. NO PRODUCER IS AUTHORIZED TO ALTER OR WAIVE ANY OF THE FOLLOWING CONDITIONS.

Subject to the limitations shown below, insurance will become effective under the receipt if the following conditions are met:

1. The application is completed in full and is unconditionally accepted and approved by Health Care Service Corporation, a Mutual Legal Reserve Company (Blue Cross and Blue Shield of Illinois) hereafter "HCSC," at its Home Office (or the office of the designated administrator).
2. The first full premium, according to the mode of premium payment chosen, has been paid and the check is honored on first presentation for payment.

   "An effective date in compliance with HCSC guidelines" means the later of:
   a. The requested coverage date, if any, shown on the application; or
   b. The date upon which the application is approved by HCSC at its Home Office (or office of the designated administrator).
3. The policy is issued by HCSC exactly as applied for within 60 days from date of application, delivered, and accepted by the proposed insured.

Applicant's Copy (if paying by check or money order)

(over, please)

AUTOMATIC PAYMENT AUTHORIZATION

I request and authorize Blue Cross and Blue Shield of Illinois (the Company) and/or its designee to obtain payment of amounts becoming due the Company by initiating charges to my account in the form of checks, share drafts, or electronic debit entries, and I request and authorize the Financial Institution named below to accept and honor the same to my account. This Authorization will remain in effect until I notify the Company or the Financial Institution in writing to terminate and the Company or the Financial Institution has a reasonable time to act on the termination.

Preferred Draft Date: _____ Check One: M Checking Account M Savings Account

NAME OF BANK WHERE ACCOUNT IS AUTHORIZED

Applicant's Copy (if paying by automatic bank withdrawal)

∂ DETACH HERE ∂

AUTOMATIC PAYMENT AUTHORIZATION

I request and authorize Blue Cross and Blue Shield of Illinois (the Company) and/or its designee to obtain payment of amounts becoming due the Company by initiating charges to my account in the form of checks, share drafts, or electronic debit entries, and I request and authorize the Financial Institution named below to accept and honor the same to my account. This Authorization will remain in effect until I notify the Company or the Financial Institution in writing to terminate and the Company or the Financial Institution has a reasonable time to act on the termination.

Preferred Draft Date:_____ Check One: M Checking Account M Savings Account

NAME OF BANK WHERE ACCOUNT IS AUTHORIZED		
ADDRESS OF BANK		
CITY	STATE	ZIP
NAME OF INSURED, APPLICANT (PRINT)		
NAME(S) OF DEPOSITOR(S) IF OTHER THAN THE INSURED	RELATIONSHIP TO INSURED	
SIGNATURE OF DEPOSITOR	DATE	

For Home Office Use Only:	BANK TRANSIT NUMBER	DEPOSITOR'S ACCOUNT NUMBER

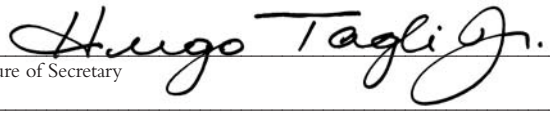
PLEASE ATTACH VOIDED CHECK OR DEPOSIT SLIP

Company's Copy (if applicant is paying by automatic bank withdrawal)

∂ DETACH HERE ∂

Limitation:

This conditional receipt does not create any temporary or interim insurance and does not provide any coverage except as expressly provided herein. In the event HCSC declines to issue a policy as applied for, the amount received by HCSC will be refunded.



Signature of Secretary

Signature of Producer

Producer's Code: _____

Blue Cross and Blue Shield of Illinois
Administrator: Hallmark Services Corp.
PO Box 2038
Aurora, Illinois 60507-2038

ALL PREMIUM CHECKS MUST BE MADE PAYABLE TO BLUE CROSS AND BLUE SHIELD OF ILLINOIS. DO NOT PAY CASH OR MAKE CHECKS PAYABLE TO THE PRODUCER OR LEAVE THE PAYEE BLANK.

If you do not hear from HCSC regarding the proposed insurance within 30 days, please call 1-800-538-8833.

THIS FORM LIMITS OUR LIABILITY.
BE SURE TO READ AND SIGN THE APPLICATION AND, IF DESIRED, THE AUTOMATIC PAYMENT REQUEST FORM. KEEP THIS DOCUMENT. IT HAS IMPORTANT INFORMATION.

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:

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

- M There are NO C.O.D.s.
- M 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.
- M 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.