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BlueChoice Value Outline of Coverage

Blue Choice Value 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 accide nt or sickness. Coverage is provided for daily Hospital room and board, miscellaneous Hospital services, surgical services, anesthesia services, In-Hospital medi cal services, and Out-of-Hospital care, subject to any Deductibles, Co-payment provisions, or other limitations which may be set forth in the Policy. Alth ough you can go to the Hospitals and Physicians of your choice, your benefits under the BlueChoice Value plan will be greater when you use the services of participa ting Hospitals and Physicians.

Plan Feature	Participating Providers	Non-Participating Providers
PPO Network	BlueChoice PPO Network	N/A
Lifetime Maximum Benefit	$5,000,000 per covered person	
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 on Deductible will apply.) **Carryover Deductible** If an insured incurs covered expenses for the Deductible in the last three months of the calendar year, BCBSIL will carry over that amount as credit toward the Deductible for the following calendar year.	Choose one of the following: $250 per individual[1] $500 per individual[1] $1,000 per individual[1] $1,750 per individual[1] $2,500 per individual[1] $5,000 per individual[1]	Choose one of the following: $750 per individual[1] $1,500 per individual[1] $3,000 per individual[1] $5,250 per individual[1] $7,500 per individual[1] $15,000 per individual[1]
Family Aggregate Deductible Per family, per calendar year.	Equal to two times the individual Deductible	
Hospital Admission Deductible Per admission, per individual.	$0	$300[1]
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.	$3,000	$6,000
Family Out-of-Pocket Expense Limit	$6,000	$12,000
Inpatient/Outpatient Physician Medical/Surgical	80%	50%
Well-Child Care To age 16. Includes immunizations, physical exams and routine diagnostic tests. ($500 calendar year maximum per dependent)	80%	50%[1]
Inpatient/Outpatient Hospital 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.)	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 ($3,000 maximum per therapy, per calendar year)	80%[1]	50%[1]
Temporomandibular Joint Dysfunction and Related Disorders ($1,000 lifetime maximum)	80%[1]	50%[1]

Plan Feature	Participating Providers	Non-Participating Providers
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 co-payment[2]	
Additional Surgical Opinion Program Following a recommendation for elective surgery, provides additional consultations and related diagnostic service by a Physician, as needed.	100%[2]	
Other Covered Services Ambulance services; durable medical equipment; services of a private duty nursing service ($1,000 per month maximum[1]); naprapathic services rendered by a Naprapath ($1,000 per calendar year maximum[1]); 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%	
Mental Illness Treatment and Substance Abuse Rehabilitation Treatment		
Inpatient Care (30 Inpatient Hospital days per calendar year)		
Physician	80%[1]	50%[1]
Hospital First 14 days	60%[1]	50%[1]
Hospital Thereafter	50%[1]	50%[1]
Outpatient Care (30 visits per calendar year combined annual maximum and 100 visits per lifetime maximum)		
Physician and Hospital	50%[1]	50%[1]

Medical Services Advisory (MSA[1])
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.[1]

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.[1]

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

1 Does not apply to out-of-pocket expense limit.
2 Deductible does not apply.

IF USING A NON-PLAN PROVIDER…

A $300 per Hospital admission Deductible will apply.[1] If using a Non-Plan Provider, benefit are reduced to 50%. However, Outpatient Hospital emergency care is paid at 80% after you pay a $75 co-payment, regardless of your coverage level or whether services ere received from an In-Network, Out-of-Network or Non-Plan Provider.

PRE-EXISTING CONDITIONS LIMITATION

Pre-existing Conditions are those health conditions which were diagnosed or treated by a Provider during the 12 months prior to the coverage effective date, or for which symptoms existed which would cause an ordinarily prudent person to seek diagnosis or treatment. Any Pre-existing Condition will be subject to a waiting period of 365 days.

PREMIUMS

Blue Cross Blue Shield of Illinois may change premium rates only if they do so on a class basis for all DB-47 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 Blue Shield of Illinois can refuse to renew this Policy only for the following reasons:

A. If all Policies bearing form number DB-47 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 Blue Shield of Illinois offer 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.

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, case finding, 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.

READ YOUR POLICY CAREFULLY — This outline of coverage provides a brief description of the important features of the 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!