MAJOR MEDICAL PLANS
AT AFFORDABLE RATES

BlueChoice℠ Select
&
BlueChoice℠ Value

BlueChoice℠ Network Plans

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

It fits your life…and your budget!
BlueChoice Select

If you want broad major medical benefits and savings of the BlueChoice network, it just fits

Try this on for size...a healthcare plan where a $30 copayment covers doctor office visits, well-child care and more...a plan that lets you select from a wide range of deductibles, to make it easy to tailor a plan to your needs and budget...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 the benefits you deserve...at a price that’s much lower than what you might expect for a major medical plan. It’s called BlueChoice Select, and it offers individual adults, individual children and families a broad range of benefits and savings. Through an agreement with providers in your area who participate in the BlueChoice network, BlueChoice Select can help you save on the cost of your coverage and the cost of covered services. In fact, with BlueChoice Select, you can save as much as 19% over our comparable major medical plan that does not use the BlueChoice contracting provider network!

BlueChoice Value

A smart choice for reliable health insurance coverage at rates to fit your budget

If you’re looking for reliable benefits at a lower premium, consider our BlueChoice Value plan. Like BlueChoice Select, it offers the money-saving advantages of the BlueChoice network and gives you the benefits you deserve — including coverage for hospitalization, doctor office visits, emergency care, outpatient prescription drugs, well-child care and optional maternity care.

Because BlueChoice Value leaves out features such as a doctor office visit copayment and a prescription drug copayment feature, you can enjoy a lower monthly premium. If you’re looking for a great combination of benefits at a price that fits your budget, choose BlueChoice Value!

1BlueChoice provides you with access to contracting providers.
$30 Office Visit Copayment with BlueChoice Select

With BlueChoice Select, you pay a $30 office visit copayment when you use contracting providers. You simply pay your doctor $30 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 $30 per visit with BlueChoice Select.

BlueChoice Select 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 $30 office visit copayment when you use contracting providers!

A Choice of Deductibles Helps You Tailor a Plan to Your Budget

Both BlueChoice Select and BlueChoice Value offer a choice of a $250, $500, $1,000, $1,750, $2,500 or $5,000 deductible. Whatever your budget, we have an option for you.

80% Coverage for Most Services

The coverage level (percentage) that BlueChoice Select and BlueChoice Value pay for covered services after you meet your deductible is called coinsurance. With 80% coinsurance, you pay 20% of your eligible bills until you’ve paid $3,000 (after you’ve met your deductible, and when you use contracting providers). At that point, both BlueChoice Select and BlueChoice Value go on to pay 100% of these services for the remainder of the calendar year.

The Security of $5,000,000 in Lifetime Protection for Yourself, Your Children or Your Whole Family

With BlueChoice Select and BlueChoice Value, individual adults, individual children and families may apply for coverage. Family coverage protects you, your spouse and your eligible unmarried dependent children. Each person will be eligible for $5,000,000 in lifetime benefits. That’s substantial protection for today and the years ahead.

Prescription Drug Coverage, Including Generic Prescriptions for a $10 Copayment with BlueChoice Select

With both plans, you get coverage for outpatient prescription medications.

When you choose a $250 or $500 deductible with BlueChoice Select:

Simply present your prescription drug card at participating pharmacies and pay a $10 copayment 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, $1,750, $2,500 or $5,000 deductible with BlueChoice Select or any deductible with BlueChoice Value:

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!
The BlueChoice Network Saves You Money!

Our BlueChoice Select and BlueChoice Value health insurance plans give you access to the BlueChoice network of contracting providers, including hospitals, physicians and specialists close to your home. Our agreements with these contracting providers allow you to save on premiums — as much as 19% over our comparable major medical plans! But that’s not all. You’ll also save on the cost of covered services when you use these contracting providers.

Your benefits are paid at the highest level when you receive care from a BlueChoice network contracting provider. You do not need to select a primary care physician to coordinate care and you don’t need a referral to see a specialist. You can receive care from a provider outside the network, but your benefits will be paid at a lower level and your out-of-pocket cost will be significantly higher.

The BlueChoice hospital network was created based on geographic accessibility, the number of board-certified physicians on staff and status with the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). Count on BlueChoice Select and BlueChoice Value to give you savings, a broad range of benefits and the flexibility you want in making your care choices.

To view a listing of BlueChoice network doctors, specialists and hospitals, visit www.bcbsil.com.

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 participating 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.

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.
Guaranteed Renewability
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 in three carries a Blue Cross and Blue Shield membership card. In fact, over 6.5 million residents across Illinois trust the Blue Cross and Blue Shield brand for their health care insurance. Blue Cross and Blue Shield of Illinois has been serving the health insurance needs of Illinois residents for more than 65 years. We’re one of the largest and most financially secure insurance companies in the state. A.M. Best, one of the leading rating agencies of the insurance industry, has awarded us an “A+” (Superior) rating.*

* As of November 2007

PRODUCER’S NEW BUSINESS CHECKLIST

For quick processing of all applications…
Use this simple checklist before submitting your applications to assure prompt processing.

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

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

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

If applicant is selecting the two-month payment mode, a check for the first two months’ premium should be submitted.

☐ If applicant is replacing his/her current coverage, make sure a signed replacement form is also attached.
THIS SALES KIT PROVIDES HEALTH INSURANCE PLAN HIGHLIGHTS ONLY.

When we receive your application, we will evaluate your medical history, and if approved, you will receive your ID card and policy.

Your coverage documents include a full description of benefits, limitations, exclusions and other features of coverage. You have 30 days to examine your coverage with no risk or obligation. We want you to be 100% satisfied. If you should change your mind about your Blue Cross and Blue Shield of Illinois policy, even after you’ve made your first premium payment, simply return your policy and membership card to your insurance representative within 30 days of the activation of the policy. If no claims were filed, you will get a refund of your premium. You’ll be under no further obligation.
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. BlueChoice Select Coverage — BlueChoice Select 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 BlueChoice Select plan will be greater when you use the services of designated Hospitals and Physicians.

### OUTLINE OF COVERAGE

#### BASIC PROVISIONS

<table>
<thead>
<tr>
<th></th>
<th>BLUECHOICE SELECT</th>
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<tbody>
<tr>
<td></td>
<td>In-Network</td>
</tr>
<tr>
<td></td>
<td>Provider Coverage</td>
</tr>
<tr>
<td><strong>Lifetime Benefit</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Deductible</strong></td>
<td></td>
</tr>
<tr>
<td>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.)</td>
<td>$250*</td>
</tr>
<tr>
<td></td>
<td>$500*</td>
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<tr>
<td></td>
<td>$1,000*</td>
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<tr>
<td></td>
<td>$1,750*</td>
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<tr>
<td></td>
<td>$2,500*</td>
</tr>
<tr>
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<td>$5,000*</td>
</tr>
<tr>
<td><strong>Carryover Deductible</strong></td>
<td></td>
</tr>
<tr>
<td>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.</td>
<td></td>
</tr>
<tr>
<td><strong>Family Aggregate Deductible</strong></td>
<td>Per family, per calendar year.</td>
</tr>
<tr>
<td><strong>Hospital Admission Deductible</strong></td>
<td>Per admission, per individual.</td>
</tr>
<tr>
<td><strong>Coinsurance</strong></td>
<td></td>
</tr>
<tr>
<td>The level of coverage provided by the plan after the calendar year Deductible has been satisfied.</td>
<td></td>
</tr>
<tr>
<td><strong>Out-of-Pocket Expense Limit</strong></td>
<td>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.</td>
</tr>
<tr>
<td><strong>Family Aggregate Out-of-Pocket Expense Limit</strong></td>
<td>Equal to two times the individual out-of-pocket limit, per family, per calendar year.</td>
</tr>
</tbody>
</table>
### Basic Provisions

<table>
<thead>
<tr>
<th>Covered Services</th>
<th>In-Network Provider Coverage</th>
<th>Out-of-Network Provider Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Outpatient Physician Medical/Surgical Services</strong>&lt;br&gt;Covered services OTHER THAN surgery, therapy, and certain diagnostic services received in a provider's office, which are described immediately below&lt;br&gt;Surgery, therapy, and certain diagnostic services including MRI, CT scan, pulmonary function studies, cardiac catheterization, EEG, EKG, ECG, and swan gantz catheterization.</td>
<td>100% after you pay $30 copayment per visit†</td>
<td>50%</td>
</tr>
<tr>
<td><strong>Inpatient Physician Medical/Surgical Services</strong></td>
<td>80%</td>
<td>50%</td>
</tr>
<tr>
<td><strong>Wellness Care</strong>&lt;br&gt;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.)&lt;br&gt;When covered services are received in a provider's office</td>
<td>100% after you pay $30 copayment per visit†</td>
<td>50%*</td>
</tr>
<tr>
<td><strong>Well-Child Care</strong>&lt;br&gt;To age 16. Includes immunizations, physical exams and routine diagnostic tests. ($500 calendar year maximum, per dependent for non-participating provider services only.)&lt;br&gt;When covered services are received OTHER THAN in a provider's office</td>
<td>100%†</td>
<td>50%*</td>
</tr>
<tr>
<td><strong>Inpatient/Outpatient Hospital Services</strong>&lt;br&gt;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.)</td>
<td>80%</td>
<td>50%</td>
</tr>
<tr>
<td><strong>Inpatient/Outpatient Hospital Diagnostic Testing</strong>&lt;br&gt;Includes, but not limited to, X-rays, lab tests, EKGs, ECGs, pathology services, pulmonary function studies, radioisotope tests, and electromyograms</td>
<td>80%</td>
<td>50%</td>
</tr>
<tr>
<td><strong>Physical, Occupational, and Speech Therapist Services</strong>&lt;br&gt;($3,000 maximum per therapy, per calendar year.)</td>
<td>80%*</td>
<td>50%*</td>
</tr>
<tr>
<td><strong>Temporomandibular Joint Dysfunction and Related Disorders</strong>&lt;br&gt;($1,000 lifetime maximum.)</td>
<td>80%*</td>
<td>50%*</td>
</tr>
<tr>
<td><strong>Optional Maternity Coverage</strong>&lt;br&gt;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.</td>
<td>80%</td>
<td>50%</td>
</tr>
<tr>
<td><strong>Outpatient Emergency Care (Accident or Illness)</strong>&lt;br&gt;For both Hospital and Physician.</td>
<td>80% after you pay $75 copayment†</td>
<td>50%</td>
</tr>
<tr>
<td><strong>Additional Surgical Opinion Program</strong>&lt;br&gt;Following a recommendation for elective surgery, provides additional consultations and related diagnostic service by a Physician, as needed.</td>
<td>100%†</td>
<td>100%†</td>
</tr>
</tbody>
</table>
**BASIC PROVISIONS**

<table>
<thead>
<tr>
<th><strong>Other Covered Services</strong></th>
<th><em><em>Ambulance services; services of a private duty nursing service ($1,000 per month maximum</em>); naprapath services rendered by a Naprapath ($1,000 per calendar year maximum</em>); oxygen and its administration; blood plasma; surgical dressings; casts and splints.**</th>
<th><strong>80%</strong></th>
</tr>
</thead>
</table>

**Mental Illness Treatment and Substance Abuse Rehabilitation Treatment**

<table>
<thead>
<tr>
<th><strong>Inpatient Care</strong></th>
<th><strong>Inpatient Hospital days per calendar year.</strong></th>
<th><strong>Outpatient Care</strong></th>
<th><strong>30 visits per calendar year combined annual maximum and 100 visits per lifetime maximum.</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician</td>
<td></td>
<td>80%*</td>
<td>50%*</td>
</tr>
<tr>
<td>Hospital First 14 days</td>
<td></td>
<td>60%*</td>
<td>50%*</td>
</tr>
<tr>
<td>Thereafter</td>
<td></td>
<td>50%*</td>
<td>50%*</td>
</tr>
</tbody>
</table>

**Medical Services Advisory (MSA*)** In order to maximize your benefits, the Policyholder is responsible for notifying the MSA for Hospital admissions at Out-of-Network and Non-Plan Hospitals. (MSA notification by the Policyholder is NOT required when services are rendered in an In-Network 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.*

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**OUTPATIENT PRESCRIPTION DRUG BENEFIT**

<table>
<thead>
<tr>
<th><strong>YOU PAY</strong></th>
<th><strong>BLUECHOICE SELECT PAYS</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Participating Pharmacy††</td>
<td>Participating Pharmacy††</td>
</tr>
</tbody>
</table>

**$250 and $500 Deductible plans ONLY**

- Generic
- Brand formulary & Insulin and Insulin syringes
- Brand non-formulary

($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
- Brand formulary & Insulin and Insulin syringes
- Brand non-formulary

**$1,000, $1,750, $2,500, and $5,000 Deductible plans ONLY**

(Subject to deductible and coinsurance.)

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

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

* Does not apply to out-of-pocket expense limit.
† Deductible does not apply.
†† Benefits will be significantly reduced if you use a non-participating pharmacy.
IF USING A NON PLAN PROVIDER...

A $300 per Hospital admission Deductible will apply.* If using a Non-Plan Provider, benefits are reduced to 50%. However, Outpatient Hospital emergency care is paid at 80% after you pay a $75 copayment, regardless of your coverage level or whether services were received from 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 We may change premium rates only if we do so on a class basis for all DB-46 HCSC policies. Premiums can be changed based on age, sex, and rating area.

GUARANTEED RENEWABILITY Coverage under this Policy will be terminated for nonpayment of premiums. In addition, Blue Cross and Blue Shield may terminate or refuse to renew this Policy only for the following reasons:

1. If every Policy that bears this Policy form number, DB-46 HCSC, is not renewed. If this should occur:
   a. Blue Cross and Blue Shield will give you at least 90 days prior to written notice.
   b. You may convert to any other individual policy Blue Cross and Blue Shield offers to the individual market.

2. In the event of fraud or an intentional misrepresentation of material fact under the terms of this Policy. In this case, Blue Cross and Blue Shield will give you at least thirty (30) days prior written notice.

3. If you no longer reside, live or work in an area for which Blue Cross and Blue Shield is authorized to do business. Blue Cross and Blue Shield will never terminate or refuse to renew this Policy because of the condition of your health. Blue Cross and Blue Shield may uniformly modify coverage provided by every Policy which bears this Policy form number only on the coverage Renewal Date.

Exclusions and Limitations:

Hospitalization, Services, and supplies which are not Medically Necessary; Services or supplies that are not specifically mentioned in this Policy; Services or supplies for any illness or injury arising out of or in the course of employment for which benefits are available under any Workers’ Compensation Law or other similar laws whether or not you make a claim for such compensation or receive such benefits except where not required by law; Services or supplies that are furnished to you by the local, state, or federal government; Services and supplies for any illness or injury occurring on or after your Coverage Date as a result of war or an act of war; Services or supplies that do not meet accepted standards of medical or dental practice; Investigational Services and Supplies, including all related services and supplies; Custodial Care Service; Routine physical examinations, unless specifically stated in this Policy; Services or supplies received during an Inpatient stay when the stay is primarily related to behavioral, social maladjustment, lack of discipline, or other antisocial actions which are not specifically the result of Mental Illness; Cosmetic Surgery and related services and supplies, except for the correction of congenital deformities or for conditions resulting from accidental injuries, scars, tumors, or diseases; Services or supplies for which you are not required to make payment or would have no legal obligation to pay if you did not have this or similar coverage; Charges for failure to keep a scheduled visit or charges for completion of a Claim form; Personal hygiene, comfort, or convenience items commonly used for other than medical purposes, such as air conditioners, humidifiers, physical fitness equipment, televisions, and telephones; Special braces, splints, specialized equipment, appliances, ambulatory apparatus, battery controlled implants, except as specifically mentioned in this Policy; Eyeglasses, contact lenses, or cataract lenses and the examinations for prescribing or fitting of glasses or contact lenses or for determining the refractive state of the eye, except as specifically mentioned in this Policy; Treatment of flat foot conditions and the prescription of supportive devices for such conditions and the treatment of subluxations of the foot or routine foot care; Immunizations, unless otherwise stated in this Policy; Maintenance Occupational Therapy, Maintenance Physical Therapy, and Maintenance Speech Therapy; Speech Therapy when rendered for the treatment of psychosocial speech delay, behavioral problems (including impulsive behavior and impulsivity syndrome), attention disorder, conceptual handicap, or mental retardation; Hearing aids or examinations for the prescription or fitting of hearing aids; Diagnostic Service as part of routine physical examinations or check-ups, premartial examinations, determination of the refractive errors of the eyes, auditory problems, surveys, caselfinding, 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.
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. BlueChoice Value Coverage — BlueChoice 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 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 BlueChoice Value plan will be greater when you use the services of designated Hospitals and Physicians.**

<table>
<thead>
<tr>
<th>BASIC PROVISIONS</th>
<th>BLUECHOICE VALUE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Lifetime Benefit</strong></td>
<td>$5,000,000</td>
</tr>
<tr>
<td><strong>Deductible</strong></td>
<td><strong>In-Network Provider Coverage</strong></td>
</tr>
<tr>
<td>Per individual, per calendar year.</td>
<td>$250*</td>
</tr>
<tr>
<td>(If two or more family members receive covered services as a result of injuries received in the same accident, only one Deductible will apply.)</td>
<td>$500*</td>
</tr>
<tr>
<td>Carryover Deductible</td>
<td>$1,000*</td>
</tr>
<tr>
<td>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.</td>
<td>$1,750*</td>
</tr>
<tr>
<td></td>
<td>$2,500*</td>
</tr>
<tr>
<td></td>
<td>$5,000*</td>
</tr>
<tr>
<td><strong>Family Aggregate Deductible</strong></td>
<td>Per family, per calendar year.</td>
</tr>
<tr>
<td><strong>Hospital Admission Deductible</strong></td>
<td>Per admission, per individual.</td>
</tr>
<tr>
<td><strong>Coinsurance</strong></td>
<td>The level of coverage provided by the plan after the calendar year Deductible has been satisfied.</td>
</tr>
<tr>
<td><strong>Out-of-Pocket Expense Limit</strong></td>
<td>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.</td>
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<tr>
<td><strong>Family Aggregate Out-of-Pocket Expense Limit</strong></td>
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</tr>
</tbody>
</table>
### BASIC PROVISIONS

<table>
<thead>
<tr>
<th>Service Description</th>
<th>In-Network Provider Coverage</th>
<th>Out-of-Network Provider Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>In-Network/Out-of-Network</strong> Provider Coverage</td>
<td>80%</td>
<td>50%</td>
</tr>
<tr>
<td><strong>Well-Child Care</strong> To age 16. Includes immunizations, physical exams, and routine diagnostic tests. ($500 per calendar year maximum, per dependent.)</td>
<td>80%</td>
<td>50%*</td>
</tr>
<tr>
<td><strong>Inpatient/Outpatient Hospital Services</strong> 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.)</td>
<td>80%</td>
<td>50%</td>
</tr>
<tr>
<td><strong>Inpatient/Outpatient Hospital Diagnostic Testing</strong> Includes, but not limited to, X-rays, lab tests, EKGs, ECGs, pathology services, pulmonary function studies, radioisotope tests, and electromyograms.</td>
<td>80%</td>
<td>50%</td>
</tr>
<tr>
<td><strong>Physical, Occupational, and Speech Therapist Services</strong> ($3,000 maximum per therapy, per calendar year.)</td>
<td>80%*</td>
<td>50%*</td>
</tr>
<tr>
<td><strong>Temporomandibular Joint Dysfunction and Related Disorders</strong> ($1,000 lifetime maximum.)</td>
<td>80%*</td>
<td>50%*</td>
</tr>
<tr>
<td><strong>Optional Maternity Coverage</strong> 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.</td>
<td>80%</td>
<td>50%</td>
</tr>
<tr>
<td><strong>Outpatient Emergency Care (Accident or Illness)</strong> For both Hospital and Physician.</td>
<td>80% after you pay $75 copayment†</td>
<td></td>
</tr>
<tr>
<td><strong>Additional Surgical Opinion Program</strong> Following a recommendation for elective surgery, provides additional consultations and related diagnostic service by a Physician, as needed.</td>
<td></td>
<td>100%†</td>
</tr>
<tr>
<td><strong>Other Covered Services</strong> Ambulance services; services of a private duty nursing service ($1,000 per month maximum*); naprapathic services rendered by a Naprapath ($1,000 per calendar year maximum*); oxygen and its administration; blood plasma; surgical dressings; casts and splints; and outpatient prescription drugs.</td>
<td></td>
<td>80%</td>
</tr>
</tbody>
</table>
**BASIC PROVISIONS**

<table>
<thead>
<tr>
<th>Mental Illness Treatment and Substance Abuse Rehabilitation Treatment</th>
<th>In-Network Provider Coverage</th>
<th>Out-of-Network Provider Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Inpatient Care</strong> (30 Inpatient Hospital days per calendar year.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physician</td>
<td>80%*</td>
<td>50%*</td>
</tr>
<tr>
<td>Hospital</td>
<td>First 14 days</td>
<td>60%*</td>
</tr>
<tr>
<td></td>
<td>Thereafter</td>
<td>50%*</td>
</tr>
<tr>
<td><strong>Outpatient Care</strong> (30 visits per calendar year combined annual maximum and 100 visits per lifetime maximum.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physician and Hospital</td>
<td>50%*</td>
<td>50%*</td>
</tr>
</tbody>
</table>

**Medical Services Advisory (MSA*)**

The MSA helps you maximize your benefits.

<table>
<thead>
<tr>
<th></th>
<th>The In-Network Provider is responsible for notifying MSA when services are rendered in an In-Network Hospital.</th>
<th>The Policyholder is responsible for notifying MSA for Hospital admissions at Out-of-Network and Non-Plan Hospitals.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>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.*</td>
<td></td>
</tr>
</tbody>
</table>

**Mental Health Unit** In order to maximize your benefits, the Policyholder is responsible for notifying the Mental Health Unit for ALL care related to mental health and substance abuse. In the event of an admission, for either mental illness or substance abuse, notification is required three days prior for non-emergencies and within 24 hours or as soon as reasonably possible for emergencies. Failure to contact the Mental Health Unit may result in a reduction of benefits of up to $1,000.*

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

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

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

† Deductible does not apply.
IF USING A NON-PLAN PROVIDER...

A $300 per Hospital admission Deductible will apply.* If using a Non-Plan Provider, benefits are reduced to 50%. However, Outpatient Hospital emergency care is paid at 80% after you pay a $75 copayment, regardless of your coverage level or whether services were received from 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 We may change premium rates only if we 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 nonpayment of premiums. In addition, Blue Cross and Blue Shield may terminate or refuse to renew this Policy only for the following reasons:

1. If every Policy that bears this Policy form number, DB-47 HCSC, is not renewed. If this should occur:
   a. Blue Cross and Blue Shield will give you at least 90 days prior to written notice.
   b. You may convert to any other individual policy Blue Cross and Blue Shield offers to the individual market.

2. In the event of fraud or an intentional misrepresentation of material fact under the terms of this Policy. In this case, Blue Cross and Blue Shield will give you at least thirty (30) days prior written notice.

3. If you no longer reside, live or work in an area for which Blue Cross and Blue Shield is authorized to do business. Blue Cross and Blue Shield will never terminate or refuse to renew this Policy because of the condition of your health. Blue Cross and Blue Shield may uniformly modify coverage provided by every Policy which bears this Policy form number only on the coverage Renewal Date.

Exclusions and Limitations:

Hospitalization, Services, and supplies which are not Medically Necessary; Services or supplies that are not specifically mentioned in this Policy; Services or supplies for any illness or injury arising out of or in the course of employment for which benefits are available under any Workers’ Compensation Law or other similar laws whether or not you make a claim for such compensation or receive such benefits; Services or supplies that are furnished to you by the local, state, or federal government; Services and supplies for any illness or injury occurring on or after your Coverage Date as a result of war or an act of war; Services or supplies that do not meet accepted standards of medical or dental practice; Investigational Services and Supplies, including all related services and supplies; Custodial Care Service; Routine physical examinations, unless specifically stated in this Policy; Services or supplies received during an Inpatient stay when the stay is primarily related to behavioral, social maladjustment, lack of discipline, or other antisocial actions which are not specifically the result of Mental Illness; Cosmetic Surgery and related services and supplies, except for the correction of congenital deformities or for conditions resulting from accidental injuries, scars, tumors, or diseases; Services or supplies for which you are not required to make payment or would have no legal obligation to pay if you did not have this or similar coverage; Charges for failure to keep a scheduled visit or charges for completion of a Claim form; Personal hygiene, comfort, or convenience items commonly used for other than medical purposes, such as air conditioners, humidifiers, physical fitness equipment, televisions, and telephones; Special braces, splints, specialized equipment, appliances, ambulatory apparatus, battery controlled implants, except as specifically mentioned in this Policy; Eyeglasses, contact lenses, or cataract lenses and the examinations for prescribing or fitting of glasses or contact lenses or for determining the refractive state of the eye, except as specifically mentioned in this Policy; Treatment of flat foot conditions and the prescription of supportive devices for such conditions and the treatment of subluxations of the foot or routine foot care; Immunizations, unless otherwise stated in this Policy; Maintenance Occupational Therapy, Maintenance Physical Therapy, and Maintenance Speech Therapy; Speech Therapy when rendered for the treatment of psychosocial speech delay, behavioral problems (including impulsive behavior and impulsivity syndrome), attention disorder, conceptual handicap, or mental retardation; Hearing aids or examinations for the prescription or fitting of hearing aids; Diagnostic Service as part of routine physical examinations or check-ups, premartial 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.
## APPLICATION FOR INDIVIDUAL COVERAGE

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

- Print all answers in blue or 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 space.
- 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 or tape.

Note: To be eligible for an HSA plan you must be 18 years or older. If choosing an HSA plan, please be reminded that Health Savings Accounts (HSA) have tax and legal ramifications. Health Care Service Corporation, d/b/a Blue Cross and Blue Shield of Illinois, does not provide legal advice, and nothing herein should be construed as legal or tax advice. Please consult your tax advisor for information regarding the tax consequences of specific health insurance plans and products.

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### 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 INFORMATION

<table>
<thead>
<tr>
<th>First Name, Middle Initial, Last Name</th>
<th>Social Security #</th>
<th>Sex</th>
<th>Age</th>
<th>Date of Birth (Mo./Day/Yr.)</th>
<th>Height (ft., in.)</th>
<th>Weight (lbs.)</th>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Residential Street Address (no P.O. Boxes)</th>
<th>City / State / ZIP</th>
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<tbody>
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</table>

<table>
<thead>
<tr>
<th>Home Phone #</th>
<th>Work Phone #</th>
<th>Cell Phone #</th>
<th>Fax #</th>
<th>Spouse’s Business Phone # (if applying)</th>
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</table>

<table>
<thead>
<tr>
<th>Email Address</th>
<th>Occupation/Duties (optional)</th>
<th>Best place and time to call (if necessary)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</table>

#### SPOUSE and UNMARRIED DEPENDENT CHILDREN YOU WISH TO COVER (Dependent children must be under age 26, or under age 30 if a military veteran.)

<table>
<thead>
<tr>
<th>NAME: First</th>
<th>M.I.</th>
<th>Last</th>
<th>RELATION</th>
<th>SEX</th>
<th>HEIGHT (ft., in.)</th>
<th>WEIGHT (lbs.)</th>
<th>DATE OF BIRTH (Mo./Day/Yr.)</th>
<th>SOCIAL SECURITY NUMBER</th>
</tr>
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</tbody>
</table>

#### SECTION B — COVERAGE APPLIED FOR (please choose only one health plan with one deductible and one level of coverage)

- **SelectBlue®**
  - Deductible: $0
  - Level of Coverage:
    - 100% 80%

- **SelectBlue Advantage℠**
  - Deductible: $250
  - Level of Coverage:
    - 80%

- **BlueChoice℠ Select**
  - Deductible: $1,750
  - Level of Coverage:
    - 80%

- **BlueValue℠**
  - Deductible: $250
  - Level of Coverage:
    - 80%

- **BlueValue Advantage℠**
  - Deductible: $250
  - Level of Coverage:
    - 80%

- **BlueChoice℠ Value**
  - Deductible: $1,750
  - Level of Coverage:
    - 80%

- **BlueEdge℠ Individual HSA**
  - Deductible: $1,200 for a single applicant or $2,400 for a family*
  - Level of Coverage:
    - 100% 80%

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

- **Traditional Blue℠**
  - Deductible: $250
  - Level of Coverage:
    - 100% 80%

- **BasicBlue®**
  - Deductible: $500
  - Level of Coverage:
    - 80%

**OPTIONAL COVERAGE:**

- Include Maternity Coverage? (NOT available on BasicBlue)
  - You MUST choose a health plan in order to apply for maternity coverage.

- BlueCare℠ Dental PPO
  - You MUST choose a health plan in order to apply for dental.
**SECTION C — 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.) _______ / _______ / _______ (Note: Day cannot be 29th, 30th or 31st.)

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  
☐ List Bill (submit a "Personal Health Insurance Certificate for Employees" form with the application)

Billing Name and Address (If different than applicant name and residential address. If an address is entered in this section, only the billing will be sent to this address; all other correspondence will be sent to the address in Section A, unless you request otherwise.)

Applicant Name ____________________________________________________________

First Name, Middle Initial, Last Name

Billing Street Address (P.O. Boxes acceptable) ________________________________

City / State / ZIP

Name of Employer (if requesting List Bill only) ________________________________

**SECTION D — HEALTH HISTORY / MEDICAL QUESTIONS**

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

If you answer "Yes" to ANY questions in Section D — Health History / Medical Questions, please give complete details in Section E — Details of Health History. Please note the timeframe reference for each question.

1. Within the last 10 years has any person applying for coverage been advised, counseled, tested, diagnosed, treated, prescribed medication, hospitalized or recommended for treatment for the following? Please answer ☐ Yes or ☐ No. If any boxes are checked "Yes" ( ☐ Yes), also circle the condition, e.g. migraines, and give details in Section E — Details of Health History.

A. Migraines; headaches; epilepsy or seizure disorder; head injury or concussion; any neurological disorder; neuropathy; paralysis; multiple sclerosis; or any other central or peripheral nervous system disorder? ...... ☐ Yes ☐ No

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

C. Chest pain; palpitations; heart murmur; mitral valve prolapse; arrhythmia or irregular heartbeat; 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. Elevated cholesterol, triglycerides or other lipids (including if controlled by diet or exercise)? ............ ☐ Yes ☐ No

If "Yes", provide the date and results of most recent testing:  
Date: ________ Total Chol: _____ HDL: _____ Triglycerides: _____

E. Varicose veins; spider veins; varicosities; anemia; blood clot or any other blood disorder? ................... ☐ Yes ☐ No

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

G. Acid reflux; gastroesophageal reflux (GERD); Barrett’s or any other disorder of the esophagus; irritable bowel syndrome (IBS); colitis; diverticulitis disease; chronic diarrhea or intestinal problem; ulcer; hernia; hemorrhoids or rectal disorder; or any other digestive disorder or condition? .......................................................... ☐ Yes ☐ No

If "Yes" to hernia, indicate type: ________________________________________________

H. Any disease or disorder of the gallbladder, pancreas or liver; elevated liver function tests; cirrhosis; hepatitis? .......................................................... ☐ Yes ☐ No

If "Yes" to hepatitis, indicate type: ________________________________________________

I. Cancer; tumor; growth; cyst; polyp; enlarged lymph nodes; leukemia? .................. ☐ Yes ☐ No

If "Yes", indicate diagnosis and location ____________________________________________

J. Acne; keratitis; psoriasis; basal cell carcinoma; malignant melanoma; lesions of the skin or mouth; hemangiomas; or any other skin disorder? .................. ☐ Yes ☐ No

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

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

M. Back or spinal disorder; herniated, bulged, protruded, ruptured or slipped disc; degenerative disc disorder; or any other injury to, disease or disorder of the back or spine? .......................................................... ☐ Yes ☐ No

N. Arthritis (e.g. osteo, rheumatoid, psoriatic, etc.); gout; bursitis; carpal tunnel syndrome; pinched nerve; bunion; temporomandibular joint syndrome (TMJ); any injury to, disease or disorder of the knees, shoulders, jaw, bones, muscles or joints; joint replacement; or received chiropractic adjustments or manipulation therapy? .................. ☐ Yes ☐ No

O. Hypothyroidism; hyperthyroidism, Graves' disease; goiter; nodule or any other thyroid disorder; diabetes; elevated blood sugar; glucose intolerance; insulin resistance or any other metabolic, endocrine, pituitary or adrenal disorder; lupus; chronic fatigue syndrome; connective tissue or autoimmune disorder? .......................................................... ☐ Yes ☐ No
For all FEMALE persons applying (adults and children)

a) Fibroid or uterine tumor; ovarian cyst; endometriosis; cystocele; rectocele; sexually transmitted disease; genital warts; herpes; HPV; or any other disease or disorder of the genital or reproductive system? □ Yes □ No

b) Has any female person had a C-section? □ Yes □ No

c) Has any female person had a pap smear? □ Yes □ No

If "Yes" for pap, provide the date and results of each person’s last 2 paps:

Name: __________________________ Date: ______/______ Normal □ Abnormal □

Name: __________________________ Date: ______/______ Normal □ Abnormal □

Name: __________________________ Date: ______/______ Normal □ Abnormal □

Name: __________________________ Date: ______/______ Normal □ Abnormal □

*Abnormal exam results include any recommendation for additional testing, medication or follow-up visit(s).

2. For EACH person applying for coverage (adults and children), complete the following information regarding their last physical exam including checkup:

Person's Name: __________________________ Exam Date (Month/Year): ______/______ Exam Results: □ Normal □ Abnormal*

Person's Name: __________________________ Exam Date (Month/Year): ______/______ Exam Results: □ Normal □ Abnormal*

Person's Name: __________________________ Exam Date (Month/Year): ______/______ Exam Results: □ Normal □ Abnormal*

Person's Name: __________________________ Exam Date (Month/Year): ______/______ Exam Results: □ Normal □ Abnormal*

*Abnormal exam results include any recommendation for additional testing, medication or follow-up visit(s).

3. During the last 5 years, has any person applying for coverage had an abnormal result from a physical exam, blood test, urinalysis, lab or diagnostic test? □ Yes □ No

4. During the last 12 months, has any person applying for coverage been prescribed or advised to take medication (other than for the common cold or flu) that is not indicated elsewhere on this application? If unsure of the reason for any ongoing medication use, please verify with your physician. □ Yes □ No

5. During the last 12 months, have you or your spouse (if to be insured) smoked or used any tobacco product – such as cigarettes, pipes, cigars, snuff or chewing tobacco, or used any smoking cessation aid or nicotine substitution product? □ Yes □ No

6. A. Question for all FEMALE persons applying (including dependents) Is any female applying for coverage now pregnant or now an expectant parent? If "Yes", coverage cannot be offered. □ Yes □ No

B. Question for all MALE persons applying (including dependents) Is any male applying for coverage now an expectant parent? If "Yes", coverage cannot be offered. □ Yes □ No

7. Has any person applying for coverage ever been seen, tested, prescribed or taken medication, or treated for infertility or to assist in becoming pregnant? □ Yes □ No

8. A. Does any person applying for coverage have or ever had an implant (e.g. breast, chin or penile implant, etc.), internal fixation (e.g. pins, plates, rods, screws or spinal cage), prosthesis, pacemaker, heart valve replacement, shunt or monitoring device other than indicated elsewhere on this application? □ Yes □ No

If "Yes" to breast implants:
B. Indicate reason(s) for breast implants: □ Cosmetic Reasons □ Disease/Illness/Injury/Congenital Anomaly

C. Have there been any complications or have either of the breast implant(s) been replaced? □ Yes □ No

9. A. Does any person applying for coverage drink beer or alcohol? If "Yes", please complete the following:

Person's Name: __________________________ Average number of drinks per week: ______

Person's Name: __________________________ Average number of drinks per week: ______

Person's Name: __________________________ Average number of drinks per week: ______

(Note: One drink is equivalent to one 12 oz. beer; or one 5 oz. glass of wine; or 1.5 oz. of hard liquor.)

B. Has any person applying for coverage ever been advised to seek treatment for alcohol use or been advised to reduce alcohol intake, or been counseled for, diagnosed with, or treated for alcohol use or abuse, alcohol dependency or alcoholism? □ Yes □ No

10. Has any person applying for coverage ever used illegal drugs or substances or been counseled for, diagnosed with, or treated for drug or chemical use (prescription, non-prescription, or illegal), or dependency? □ Yes □ No

11. 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

12. Has any person applying for coverage ever been seen, treated, hospitalized, or had surgery for a bypass, angioplasty, stent, aneurysm, valve replacement, cancer, stroke, gastric or weight loss surgery, congenital abnormality, or organ transplant other than indicated elsewhere on this application? □ Yes □ No
If you answered “Yes” to ANY questions in Section D - Health History / Medical Questions OR have had an abnormal exam or test, please provide further information in the space 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.)

<table>
<thead>
<tr>
<th>Question Number</th>
<th>Person Affected</th>
<th>Condition, Injury, Symptom, or Diagnosis</th>
<th>Description (specify left or right, if applicable)</th>
<th>Date that it started</th>
<th>Date of Recovery Complete?</th>
<th>Date Last Treated (if applicable)</th>
<th>Types of Treatment, Advice Given, and Medications Prescribed</th>
<th>Name, City, State, and Phone Number of Doctors and Hospitals</th>
</tr>
</thead>
</table>
| Example: 3C     | Joe Smith       | High Blood Pressure                      | 6/95                                              | none                 | no, ongoing              | 40mg Atenolol once a day         | Today, still using medicine                                    | Dr. Jones  
St. Mary’s Peoria, IL  
(309) 555-1212  |
SECTION F — OTHER INSURANCE INFORMATION

1. Does any person applying for coverage currently have, or did they previously have within the last 5 years, Blue Cross and Blue Shield of Illinois coverage, either as a primary insured, spouse or as a dependent? □ Yes □ No If “Yes”, please complete the following:

   Applicant Name __________________________________________________________
   Name __________________________________________________________
   Name __________________________________________________________
   Insurer Name(s): _______________________________________________
   Location / State: ___________________________________________
   Policy Effective Date: ________________________ Anticipated Policy Termination Date: ________________________

2. Does any person applying for coverage currently have health or major medical insurance coverage with any other Insurer, including other Blue Cross and Blue Shield plans? □ Yes □ No If “Yes”, please complete the following:

   Applicant Name(s) of all individuals covered: _______________________________
   Location / State: ___________________________________________
   Policy Effective Date: ________________________ Anticipated Policy Termination Date: ________________________

3. If “Yes” to either question 1 or 2 above, is the issuance of this coverage replacing your existing coverage? □ Yes □ No

   If “Yes”, when is coverage to be replaced (mo./day/yr)? _______ / _______ / _______

   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 or cancelled? □ 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.

NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS INSURANCE

If you answered “Yes” to Question 3 above, you intend to lapse or otherwise terminate existing accident and sickness insurance and replace it with a contract to be issued by Blue Cross and Blue Shield of Illinois. For your own information and protection, you should be aware of and seriously consider certain factors that may affect the insurance protection available to you under the new contract.

1. Health conditions which you may presently have may not be immediately or fully covered under the new contract. This could result in denial or delay of a claim for benefits under the new contract, whereas a similar claim might have been payable under your present contract.

2. You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present contract. 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 contract and replace it with new coverage, be certain to truthfully and completely answer all questions on this application concerning the medical/health history of all persons applying for coverage. Failure to include all material medical information on any application may provide the basis for the company to deny any future claims and to refund your premium as though your contract had never been in force. After the application has been completed and before you sign it, re-read it carefully to be certain that all information has been properly recorded.

4. It is recommended, that you not terminate your present contract until you are certain that your application for the new contract has been accepted by Blue Cross and Blue Shield of Illinois.

SECTION G — REPRESENTATIONS, ACKNOWLEDGEMENTS, AND AUTHORIZATIONS

I apply for coverage as indicated in Section B, 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 this application, and represent that they are true and complete to the best of my knowledge and belief. I understand that failure to disclose information on 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. I have been informed 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).

If requesting List Bill, I direct my employer to deduct from my pay and remit the entire cost of coverage selected. This authorization is to remain in effect until the Company is notified by me or my employer in writing to the contrary. 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 even if I have requested List Bill.

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.
The undersigned hereby appoints the Board of Directors of Health Care Service Corporation, a Mutual Legal Reserve Company, 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. We must also receive your application within 30 days of the earliest date signed, so please return promptly. Applications received after 30 days will require a new application.

APPLICANT'S SIGNATURE(S)

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. We must also receive your application within 30 days of the earliest date signed, so please return promptly. Applications received after 30 days will require a new application.

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

Spouse 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 Signature
(ONLY if 18 or over and ONLY if to be insured): X Date Signed: / / Mo./Day/Yr.

Dependent Signature
(ONLY if 18 or over and ONLY if to be insured): X Date Signed: / / Mo./Day/Yr.

Dependent Signature
(ONLY if 18 or over and ONLY if to be insured): X Date Signed: / / Mo./Day/Yr.

Dependent Signature
(ONLY if 18 or over and ONLY if to be insured): X Date Signed: / / Mo./Day/Yr.

If any question(s), you may (1) call our Customer Service Department toll-free at 1-800-654-7385, or (2) call your insurance agent at their number below, or (3) visit www.bcbsil.com.

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

Primary Applicant Signature (optional): X

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

SECTION H — AGENT INFORMATION (if applicable)

The applicant acknowledges that any agent is acting on his/her behalf for purposes of purchasing the insurance, and that if HCSC accepts this application and issues an Individual Policy, HCSC may pay the agent a commission and/or other compensation in connection with the insurance of such Individual Policy. The applicant further acknowledges that if he/she desires additional information regarding any commissions or other compensation paid the agent by HCSC in connection with the issuance of the Individual Policy, he/she should contact the agent.

Agent Signature: X Date Signed: / / Mo./Day/Yr.

Print Agent Name: Agent Code:

Agent Phone Number: ( ) Agent Fax Number: ( )

Agent Email Address: Mail Policy(ies) to: ☐ Agent ☐ Applicant
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 HAS 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.

Note to Producer: An applicant who is replacing existing health insurance with Blue Cross and Blue Shield coverage must read, sign, and date the adjacent replacement form at right. You must then submit that replacement form along with the application. This half of the form must remain with the applicant.

The above “Notice to Applicant” was delivered to me on:

_________________________________________________________________
(Date)

_________________________________________________________________
(Applicant’s Signature)

_________ - ______ - ________
(Applicant’s Social Security Number)
CONDITIONAL RECEIPT FOR

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 latter 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.

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: □ Checking Account □ Savings Account

NAME OF BANK WHERE ACCOUNT IS AUTHORIZED

APPLICANT'S COPY (IF PAYING BY CHECK OR MONEY ORDER)

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: □ Checking Account □ 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)
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 3236  
Naperville, Illinois  60566-7236

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.