BlueCross BlueShield of Illinois

Blue FocusCare Bronze HMO 104
Blue FocusCare HMO℠

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. Blue FocusCare HMO – Blue FocusCare HMO 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, Copayments or other limitations which may be set forth in your Policy. **The services you receive under the Policy must be provided by or ordered by your Primary Care Physician or Woman's Principal Health Care Provider.** To receive benefits for treatment from another Physician or Provider, you must be referred to that Provider by your Primary Care Physician or Woman's Principal Health Care Provider. The referral must be in writing and must specifically state the services that are to be rendered. Benefits will be limited to those specifically stated services.

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

BASIC PROVISIONS	**Blue FocusCare Bronze HMO 104**
	YOUR COST
Deductible Per individual, per calendar year	$7,100*
Family Aggregate Deductible Per family, per calendar year	$14,300*
Out-of-Pocket Expense Limitation* **(does not apply to all services)** Individual Family	$7,150 $14,300
PHYSICIAN BENEFITS	
Copayment for Outpatient Physician office visits *(except for Outpatient periodic health examinations, routine pediatric care, routine vision examinations, chiropractic and osteopathic manipulations and maternity services after the first pre-natal visit)*	$50 per Visit
Copayment for Outpatient Specialist office visits	$100 per Visit

Preventive Care Services Benefits will be provided for the following Covered Services and will not be subject to Coinsurance, deductible, Copayment or dollar maximum (to be implemented in the quantity and at the time required by applicable law): Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force (USPSTF); immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and prevention with respect to the individual involved; evidenced-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA) for infants, children, and adolescents; and additional preventive care and screenings provided for in comprehensive guidelines supported by the HRSA. For purposes of this benefit, the current recommendations of the USPSTF regarding breast cancer screening and mammography and prevention will be considered the most current (other than those issued in or around November 2009). (including but not limited to Outpatient periodic health examinations, routine pediatric care, pediatric vision examinations)	None

Copayment for Outpatient Occupational, Physical and Speech Therapy Treatments	$250 per Treatment
Copayment for Outpatient Surgery	$250 per Visit
Outpatient Office Visits for the Treatment of Mental Illness Other Than Serious Mental Illness When Not Authorized by Primary Care Physician or Woman's Principal Health Care Provider	50% of Provider's Charge, after the program deductible
HOSPITAL BENEFITS	
Copayment for Inpatient Hospital Admission	$750 per Day
Inpatient Treatment of Mental Illness Other than Serious Mental Illness When Not Authorized by Primary Care Physician or Woman's Principal Health Provider	50% of the Eligible Charge, after the program deductible
Copayment for Outpatient Surgery Outpatient Surgery Copayment	
Free Standing Facility	$500 per Visit, then 50% of the Eligible Charge after the program deductible
Hospital	$500 per Visit, then 50% of the Eligible Charge, after the program deductible
Copayment for Certain Diagnostic Tests: **Computerized Tomography (CT Scan)** **Positron Emission Tomography (PET Scan)** **Magnetic Resonance Imaging (MRI):**	
Free Standing Facility	$400 per Procedure
Hospital	$800 per Procedure
Copayment for Outpatient Diagnostic Services other than: **Computerized Tomography (CT Scan),** **Positron Emission Tomography, (PET Scan)** **Magnetic Resonance Imaging (MRI):**	
Free Standing Facility	$150 per Procedure
Hospital	$300 per Procedure
Copayment for Urgent Care	$100 per Visit
All Other Outpatient Covered Services	50% of the Eligible Charge, after the program deductible
SUPPLEMENTAL BENEFITS	
Supplemental Benefits Blood and blood components; Outpatient Private Duty Nursing, medical and surgical dressings, supplies, casts and splints, oxygen and its administration, naprapathic services, prosthetic devices, orthotic devices and durable medical equipment	50% of the Eligible Charge, after the program deductible

EMERGENCY CARE SERVICES BENEFITS	
Copayment for Emergency Care Services (In-Area or Out-of-Area)	$1,000 per Visit, then 50% of the Eligible Charge, after the program deductible *(deductible waived if admitted to Hospital as an Inpatient immediately following emergency treatment)*
Emergency Ambulance Transportation	50% of the Eligible Charge, after the program deductible
SUBSTANCE USE DISORDER BENEFITS	
Copayment for Inpatient Hospital Admission for Substance Use Disorder Treatment	$750 per Day
Copayment for Outpatient office visits for Substance Use Disorder Treatment	$50 per Visit
Copayment for Outpatient specialist office visits for Substance Use Disorder Treatment	$50 per Visit
OUTPATIENT PRESCRIPTION DRUG PROGRAM	
30-Day Supply Outpatient Prescription Drug Program	
Formulary Generic Drugs, other than Specialty Drugs, and Formulary Generic Diabetic Supplies and insulin and insulin syringes	$5 per Prescription
Non-Formulary Generic Drugs, other than Specialty Drugs, and Non-Formulary Generic Diabetic Supplies and insulin and insulin syringes	20% of the Eligible Charge per Prescription, after the program deductible
Formulary Brand-name Drugs, other than Specialty Drugs, and Formulary Brand-name Diabetic Supplies and insulin and insulin syringes	20% of the Eligible Charge per Prescription, after the program deductible
Formulary Brand-name Specialty Drugs and Non-Formulary Brand-name Drugs and Non-Formulary Brand-name Diabetic Supplies and insulin and insulin syringes	30% of the Eligible Charge per Prescription, after the program deductible
Non-Formulary Brand-name Specialty Drugs and insulin and insulin syringes	40% of the Eligible Charge per Prescription, after the program deductible
90-Day Supply Outpatient Prescription Drug Program	
Formulary Generic Drugs and Formulary Generic Diabetic Supplies and insulin and insulin syringes	$15 per Prescription
Non-Formulary Generic Drugs and Non-Formulary Generic Diabetic Supplies and insulin and insulin syringes	20% of the Eligible Charge per Prescription, after the program deductible

Formulary Brand-name Drugs and Formulary Brand-name Diabetic Supplies and insulin and insulin syringes	20% of the Eligible Charge per Prescription, after the program deductible
Non-Formulary Brand-name Drugs and Non-Formulary Brand-name Diabetic Supplies and insulin and insulin syringes	30% of the Eligible Charge per Prescription, after the program deductible

DEPENDENT LIMITING AGE	
Limiting Age for Dependent Children *(regardless of presence or absence of child's financial dependency, residency, student status, employment status, marital status, eligibility for other coverage or any combination of these factors).*	26
PEDIATRIC VISION CARE SERVICES	
Exams, Lenses, Frames and Contact Lenses	None
Low vision services and Laser vision correction Surgery (Lasik)	Traditional and custom Lasik Surgery will be provided at a discount from Participating Physicians and affiliated laser centers.

* The program deductible and Out-of-Pocket Expense Limitation amounts may be subject to change or increase as permitted by applicable law.

GUARANTEED RENEWABILITY

Coverage under the Policy will be terminated for nonpayment of premiums. Blue Cross and Blue Shield may terminate or refuse to renew the Policy for any of the following reasons:

1. If every Policy that bears the Policy form number, is not renewed or if Blue Cross and Blue Shield ceases to offer a particular type of coverage in the individual market. If this should occur:
   a. Blue Cross and Blue Shield will give you at least 90 days prior written notice, or such other notice, if any, permitted by applicable law or regulatory guidance.
   b. You may convert to any other individual policy offered to the individual market.
   c. If Blue Cross and Blue Shield should terminate or refuse to terminate the Policy, it must do so uniformly without regard to any health status-related factor of covered individuals or dependents of covered individuals who may become eligible for coverage.
2. If Blue Cross and Blue Shield discontinue all health care coverage and does not renew all health insurance policies it issues or delivers for issuance in the individual market in the state of Illinois. If this should occur, Blue Cross and Blue Shield will give you at least 180 days prior written notice, or such other notice, if any, permitted by applicable law or regulatory guidance.
3. In the event of fraud or an intentional misrepresentation of material fact under the terms of the Policy. In this case, Blue Cross and Blue Shield will give you at least 30 days prior written notice, or such other notice, if any, permitted by applicable law or regulatory guidance.
4. You no longer reside, live or work in the Blue Cross and Blue Shield of Illinois' network service area.
5. Failure to pay your premium in accordance with the terms of the Policy.
6. Other reasons described in the Policy.

Blue Cross and Blue Shield will never terminate or refuse to renew the Policy because of the condition of your health.

EXCLUSIONS AND LIMITATIONS:

Services or supplies that were not ordered by your Primary Care Physician or Woman's Principal Health Care Provider except as explained in the EMERGENCY CARE BENEFITS section, HOSPITAL BENEFITS section and for Mental Illness (other than Serious Mental Illness) or for routine vision examinations, PHYSICIAN BENEFITS section of the Policy.

Services or supplies that were received prior to the date your coverage began or after the date that your coverage was terminated, unless otherwise stated in the Policy.

Services or supplies for which benefits have been paid under any Workers' Compensation Law or other similar laws whether or not you make a claim for such compensation or receive such benefits. However, this exclusion shall not apply if you are a corporate officer of any business or enterprise, defined as a "small business" under paragraph (b), Section 3 or the Illinois Small Business Purchasing Act, as amended, and are employed by the corporation and elect to withdraw yourself from the operation of the Illinois Workers' Compensation Act according to the provisions of the Act.

Services or supplies that are furnished to you by the local, state or federal government and services or supplies to the extent payments or benefits for such services or supplies are provided by or available from the local, state or federal government (for example, Medicare) whether or not those payments or benefits are received, except however, this exclusion shall not be applicable to medical assistance benefits under Article V, VI or VII of the Illinois Public Aid Code (Ill. Rev. Stat. Ch. 23 §1-1 et seq.) or similar legislation of any state, benefits provided in compliance with the Tax Equity and Fiscal Responsibility Act or as otherwise provided by law.

Services or supplies rendered to you as the result of an injury caused by another person to the extent that you have collected damages for such injury and that Blue Cross and Blue Shield has provided benefits for the services or supplies rendered in connection with such injury.

Services or supplies that do not meet accepted standards of medical or dental practice including, but not limited to, services which are Experimental/Investigational in nature, except as specifically provided for in the Policy for a) the cost of routine patient care associated with Experimental/Investigational treatment if you are a qualified individual participating in an Approved Clinical Trial, if those services or supplies would otherwise be covered under the Policy if not provided in connection with an Approved Clinical Trial program and b) applied behavior analysis used for the treatment of Autism Spectrum Disorder(s).

Custodial Care Service.

Long Term Care Services.

Respite Care Services, except as specifically mentioned under Hospice Care Benefits section of the Policy.

Services or supplies received during an Inpatient stay when the stay is solely related to behavioral, social maladjustment, lack of discipline or other antisocial actions which are not specifically the result of Mental Illness. This does not include services or supplies provided for the treatment of an injury resulting from an act of domestic violence or a medical condition (including both physical and mental health conditions).

Special education therapy such as music therapy or recreational therapy, except as specifically provided for in the Policy.

Cosmetic Surgery and related services and supplies, except for the correction of congenital deformities or for conditions resulting from accidental injuries, tumors or disease.

Services or supplies received from a dental or medical department or clinic maintained by an employer, labor union or other similar person or group.

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 or charges for the transfer of medical records.

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 or, battery implants except as specifically stated in the Policy.

Prosthetic devices, special appliances or surgical implants which are for cosmetic purposes, the comfort or convenience of the patient or unrelated to the treatment of disease or injury.

Nutritional items such as infant formula, weight-loss supplements, over-the-counter food substitutes and non-prescription vitamins and herbal supplements, except as stated in the Policy.

Blood derivatives which are not classified as drugs in the official formularies.

Hypnotism.

Inpatient Private Duty Nursing Service.

Routine foot care, except for persons diagnosed with diabetes.

Maintenance Occupational Therapy, Maintenance Physical Therapy and Maintenance Speech Therapy, except as specifically stated in the Policy.

Maintenance Care.

Self-management training, education and medical nutrition therapy, except as specifically stated in the Policy.

Habilitative Services that are solely educational in nature or otherwise paid under state or federal law for purely educational services.

Services or supplies which are rendered for the care, treatment, filling, removal, replacement or artificial restoration of the teeth or structures directly supporting the teeth except as specifically stated in the Policy.

Repair or replacement of appliances and/or devices due to