**The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, visit http://www.bcbsil.com/policy-forms/2018/IL0990127-00.pdf or by calling 1-800-538-8833. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/UG-Glossary-508-MM.pdf or call 1-855-756-4448 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | Individual:<br>Participating $5,500<br>Non-Participating $15,000<br>Family:<br>Participating $14,700<br>Non-Participating $45,000 | Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible. |
| **Are there services covered before you meet your deductible?** | Doesn't apply to preventive care & certain copayments. | This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/. |
| **Are there other deductibles for specific services?** | No. | You don't have to meet deductibles for specific services. |
| **What is the out-of-pocket limit for this plan?** | Individual:<br>Participating $7,350<br>Non-Participating Unlimited<br>Family:<br>Participating $14,700<br>Non-Participating Unlimited | The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met. |
| **What is not included in the out-of-pocket limit?** | Premiums, balance-billed charges, and health care this plan doesn't cover. | Even though you pay these expenses, they don't count toward the out-of-pocket limit. |
| **Will you pay less if you use a network provider?** | See www.bcbsil.com or call **1-800-538-8833** for a list of Participating providers. | This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services. |
| **Do you need a referral to see a specialist?** | No. You don't need a referral to see a Specialist. | You can see the specialist you choose without a referral. |

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Participating Provider (You will pay the least) | Non-Participating Provider (You will pay the most) | |
| **If you visit a health care provider's office or clinic** | Primary care visit to treat an injury or illness | $40/visit or 50% coinsurance | 50% coinsurance | First 2 visits are $40/visit. Virtual visits may be available, please refer to your plan policy for more details. |
| | Specialist visit | 50% coinsurance | 50% coinsurance | None. |
| | Preventive care/screening/ immunization | No Charge, deductible does not apply | 50% coinsurance | You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. *Then check what your plan will pay for. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | Hospital - 50% coinsurance<br>Non-Hospital - 40% coinsurance | 50% coinsurance | None. |
| | Imaging (CT/PET scans, MRIs) | Hospital - 50% coinsurance<br>Non-Hospital - 40% coinsurance | 50% coinsurance | Preauthorization is required for certain services. *See benefit booklet for more details. |
| **If you need drugs to treat your illness or condition**<br><br>More information about **prescription drug coverage** is available at https://www.myprime.com/content/dam/prime/memberportal/forms/AuthorForms/HIM/2018/IL_6T_EX.pdf | Preferred generic drugs | Retail Preferred - $10/prescription<br>Non-Preferred $20/prescription<br>Mail - $30/prescription<br>deductible does not apply | Retail - $20/prescription deductible does not apply | Limited to a 30-day supply at retail (or a 90-day supply at a network of select retail pharmacies). Up to a 90-day supply at mail order. Specialty drugs limited to a 30-day supply. Payment of the difference between the cost of a brand name drug and a generic may also be required if a generic drug is available. All Out-of-Network prescriptions are subject to a 50% additional charge after the applicable copay/coinsurance. Additional charge will not apply to any deductible or out-of-pocket amounts. You may be eligible to synchronize your prescription refills, |
| | Non-preferred generic drugs | Retail Preferred - $20/prescription<br>Non-Preferred $30/prescription<br>Mail - $60/prescription<br>deductible does not apply | Retail - $30/prescription deductible does not apply | |

*For more information about limitations and exceptions, see the plan or policy document at http://www.bcbsil.com/policy-forms/2018/IL0990127-00.pdf.

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Participating Provider (You will pay the least) | Non-Participating Provider (You will pay the most) | |
| | Preferred brand drugs | Preferred - 30% coinsurance/ Non-Preferred - 35% coinsurance | 35% coinsurance | *please see your benefit booklet for details. |
| | Non-preferred brand drugs | Preferred - 35% coinsurance/ Non-Preferred - 40% coinsurance | 40% coinsurance | |
| | Preferred specialty drugs | 45% coinsurance | 45% coinsurance | |
| | Non-Preferred specialty drugs | 50% coinsurance | 50% coinsurance | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | Hospital - $600/visit plus 50% coinsurance Non-Hospital - $600 /visit plus 40% coinsurance | $1,500/visit plus 50% coinsurance | Abortions not covered, except where a pregnancy is the result of rape or incest, or for a pregnancy which, as certified by a physician, places the woman in danger of death unless an abortion is performed. |
| | Physician/surgeon fees | $200/visit plus 50% coinsurance | 50% coinsurance | |
| **If you need immediate medical attention** | Emergency room care | $1,000/visit plus 50% coinsurance | $1,000/visit plus 50% coinsurance | Copayment waived if admitted. |
| | Emergency medical transportation | 50% coinsurance | 50% coinsurance | Ground and air transportation covered. |
| | Urgent care | $60/visit, deductible does not apply | 50% coinsurance | None. |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | $850/visit plus 50% coinsurance | $1,500/visit plus 50% coinsurance | Preauthorization required. Failure to preauthorize may result in claim denial. Preauthorization requirement is waived if admitted from the emergency room. |
| | Physician/surgeon fees | 50% coinsurance | 50% coinsurance | |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | 50% coinsurance | 50% coinsurance | Preauthorization is required for Psychological testing; Neuropsychological testing; Electroconvulsive therapy; Repetitive Transcranial magnetic Stimulation; Autism |
| | Inpatient services | $850/visit plus 50% coinsurance | $1,500/visit plus 50% coinsurance | |

*For more information about limitations and exceptions, see the plan or policy document at http://www.bcbsil.com/policy-forms/2018/IL0990127-00.pdf.

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Participating Provider (You will pay the least) | Non-Participating Provider (You will pay the most) | |
| | | | | Spectrum Disorder; and Intensive Outpatient Treatment. |
| **If you are pregnant** | Office visits | $40/visit and coinsurance | 50% coinsurance | Cost sharing does not apply for preventive services. Depending on the type of services, a coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Inpatient copayment is charged in addition to the overall deductible. Service provided at no charge with CHS referral. |
| | Childbirth/delivery professional services | 50% coinsurance | 50% coinsurance | |
| | Childbirth/delivery facility services | $850/visit plus 50% coinsurance | $1,500/visit plus 50% coinsurance | |
| **If you need help recovering or have other special health needs** | Home health care | 50% coinsurance | 50% coinsurance | Preauthorization required. Failure to preauthorize may result in claim denial. |
| | Rehabilitation services | 50% coinsurance | 50% coinsurance | |
| | Habilitation services | 50% coinsurance | 50% coinsurance | |
| | Skilled nursing care | 50% coinsurance | 50% coinsurance | |
| | Durable medical equipment | 50% coinsurance | 50% coinsurance | Benefits are limited to items used to serve a medical purpose. DME benefits are provided for both purchase and rental equipment (up to the purchase price). |
| | Hospice services | 50% coinsurance | 50% coinsurance | Preauthorization required. Failure to preauthorize may result in claim denial. |
| **If your child needs dental or eye care** | Children's eye exam | No Charge | Not Covered | One visit per year. *See benefit booklet for network details. |
| | Children's glasses | No Charge | Not Covered | One pair of glasses per year. *See benefit booklet for network details. |
| | Children's dental check-up | Not Covered | Not Covered | None |

*For more information about limitations and exceptions, see the plan or policy document at http://www.bcbsil.com/policy-forms/2018/IL0990127-00.pdf.

## Excluded Services & Other Covered Services:

**Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)**

- Abortions (Except where a pregnancy is the result of rape or incest, or for a pregnancy which, as certified by a physician, places the woman in danger of death unless an abortion is performed)
- Acupuncture
- Dental Care (Adult)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care
- Weight loss programs

**Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document)**

- Bariatric surgery
- Chiropractic care (Limited to 25 visits per calendar year.)
- Cosmetic surgery (Only for the correction of congenital deformities or conditions resulting from accidental injuries, scars, tumors, or diseases)
- Hearing aids (Two covered every 36 months for children or bone anchored)
- Infertility treatment (Covered for 4 procedures per benefit period)
- Private-duty nursing (With the exception of inpatient private duty nursing)
- Routine foot care (Only in connection with diabetes)

## Your Rights to Continue Coverage:

There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the plan at 1-800-538-8833. You may also contact your state insurance department at 1-877-527-9431. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Blue Cross and Blue Shield of Illinois at 1-800-538-8833 or visit **www.bcbsil.com**, or contact the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or visit **www.dol.gov/ebsa/healthreform.**

Additionally, a consumer assistance program can help you file your appeal. Contact the Illinois Department of Insurance at (877) 527-9431 or visit **http://insurance.illinois.gov**.

## Does this plan provide Minimum Essential Coverage? Yes

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

## Does this plan meet the Minimum Value Standards? Yes

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

## Language Access Services:

Spanish (Español): Spanish (Español): Para obtener asistencia en Español, llame al 1-800-538-8833.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-538-8833.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-538-8833.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-538-8833.

*To see examples of how this plan might cover costs for a sample medical situation, see the next section.*

## About These Coverage Examples:

**This is not a cost estimator.** Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

### Peg is Having a baby
(9 months of in-network pre-natal care and a hospital delivery)

| | |
|---|---|
| **The plan's overall deductible** | $5,500 |
| **Specialist coinsurance** | 50% |
| **Hospital (facility) both** | $850 + 50% |
| **Other coinsurance** | 50% |

**This EXAMPLE event includes services like**:
Specialist office visits (*prenatal care*)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

| **Total Example Cost** | **$12,800** |
|---|---|

**In this example, Peg would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $5,500 |
| Copayments | $900 |
| Coinsurance | $1,000 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$7,460** |

### Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

| | |
|---|---|
| **The plan's overall deductible** | $5,500 |
| **Specialist coinsurance** | 50% |
| **Hospital (facility) both** | $850 + 50% |
| **Other coinsurance** | 50% |

**This EXAMPLE event includes services like**:
Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

| **Total Example Cost** | **$7,400** |
|---|---|

**In this example, Joe would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $5,500 |
| Copayments | $600 |
| Coinsurance | $100 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Joe would pay is** | **$6,260** |

### Mia's Simple Fracture
(in-network emergency room visit and follow up care)

| | |
|---|---|
| **The plan's overall deductible** | $5,500 |
| **Specialist coinsurance** | 50% |
| **Hospital (facility) both** | $850 + 50% |
| **Other coinsurance** | 50% |

**This EXAMPLE event includes services like**:
Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

| **Total Example Cost** | **$1,900** |
|---|---|

**In this example, Mia would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $1,900 |
| Copayments | $0 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$1,900** |

The **plan** would be responsible for the other costs of these EXAMPLE covered services.

BlueCross BlueShield of Illinois

If you, or someone you are helping, have questions, you have the right to get help and information in your language at no cost.
To speak to an interpreter, call the customer service number on the back of your member card. If you are not a member, or don't have a card, call 855-710-6984.

| | |
|---|---|
| العربية<br>Arabic | إن كان لديك أو لدى شخص تساعده أسئلة، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون اية تكلفة. للتحدث إلى مترجم فوري، اتصل على رقم خدمة العملاء المذكور على ظهر بطاقة عضويتك. فإن لم تكن عضوًا، أو كنت لا تملك بطاقة، فاتصل على 855-710-6984. |
| 繁體中文<br>Chinese | 如果您, 或您正在協助的對象, 對此有疑問, 您有權利免費以您的母語獲得幫助和訊息。洽詢一位翻譯員, 請致電印在您的會員卡背面的客戶服務電話號碼。如果您不是會員, 或沒有會員卡, 請致電 855-710-6984。 |
| Français<br>French | Si vous, ou quelqu'un que vous êtes en train d'aider, avez des questions, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, composez le numéro du service client indiqué au verso de votre carte de membre. Si vous n'êtes pas membre ou si vous n'avez pas de carte, veuillez composer le 855-710-6984. |
| Deutsch<br>German | Falls Sie oder jemand, dem Sie helfen, Fragen haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Kundenservicenummer auf der Rückseite Ihrer Mitgliedskarte an. Falls Sie kein Mitglied sind oder keine Mitgliedskarte besitzen, rufen Sie bitte 855-710-6984 an. |
| Ελληνικά<br>Greek | Εάν εσείς ή κάποιος που βοηθάτε έχετε ερωτήσεις, έχετε το δικαίωμα να λάβετε βοήθεια και πληροφορίες στη γλώσσα σας χωρίς χρέωση. Για να μιλήσετε σε έναν διερμηνέα, καλέστε τον αριθμό εξυπηρέτησης πελατών που αναγράφεται στο πίσω μέρος της κάρτας μέλους σας. Εάν δεν είστε μέλος ή δεν έχετε κάρτα, καλέστε τον αριθμό 855-710-6984. |
| ગુજરાતી<br>Gujarati | જો તમને અથવા તમે મદદ કરી રહ્યા હોય એવી કોઈ બીજી વ્યક્તિને એસ.બી.એમ. દુભાષિયા સાથે વાત કરવા માટે, તમારા સભ્યપદના કાર્ડની પાછળ આપેલ ગ્રાહક સેવા નંબર પર કૉલ કરો. જો આપ સભ્યપદ ના ધરાવતા હોવ, અથવા આપની પાસે કાર્ડ નથી તો 855-710-6984 નંબર પર કૉલ કરો. |
| हिंदी<br>Hindi | यदि आपके, या आप जिसकी सहायता कर रहे हैं उसके, प्रश्न हैं, तो आपको अपनी भाषा में निःशुल्क सहायता और जानकारी प्राप्त करने का अधिकार है। किसी अनुवादक से बात करने के लिए, अपने सदस्य कार्ड के पीछे दिए गए ग्राहक सेवा नंबर पर कॉल करें। यदि आप सदस्य नहीं हैं, या आपके पास कार्ड नहीं है, तो 855-710-6984 पर कॉल करें। |
| Italiano<br>Italian | Se tu o qualcuno che stai aiutando avete domande, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare il servizio clienti al numero riportato sul lato posteriore della tua tessera di socio. Se non sei socio o non possiedi una tessera, puoi chiamare il numero 855-710-6984. |
| 한국어<br>Korean | 만약 귀하 또는 귀하가 돕는 사람이 질문이 있다면 귀하는 무료로 그러한 도움과 정보를 귀하의 언어로 받을 수 있는 권리가 있습니다. 회원 카드 뒷면에 있는고객 서비스 번호로 전화하십시오. 회원이 아니시거나 카드가 없으시면 855-710-6984 으로 전화주십시오. |
| Diné<br>Navajo | T'áá ni, éí doodago ła'da bíká anánílwo'ígíí, na'ídíłkidgo, ts'ídá bee ná ahóóti'i' t'áá níík'e níká a'doolwoł. Ata' halne'í bich'į' hadeesdzih nínízingo éí kwe'é da'íníishgi áká anídaalwo'ígíí bich'į' hodíílnih, bee nééhózinii bine'dęę' bikáá'. Kojí atah naaltsoos ná hadít'éégóó éí doodago bee nééhózinígíí ádingo kojį' hodíílnih 855-710-6984. |
| Polski<br>Polish | Jeśli Ty lub osoba, której pomagasz, macie jakiekolwiek pytania, macie prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer podany na odwrocie karty członkowskiej. Jeżeli nie jesteś członkiem lub nie masz przy sobie karty, zadzwoń pod numer 855-710-6984. |
| Русский<br>Russian | Если у вас или человека, которому вы помогаете, возникли вопросы, у вас есть право на бесплатную помощь и информацию, предоставленную на вашем языке. Чтобы поговорить с переводчиком, позвоните в отдел обслуживания клиентов по телефону, указанному на обратной стороне вашей карточки участника. Если вы не являетесь участником или у вас нет карточки, позвоните по телефону 855-710-6984. |
| Español<br>Spanish | Si usted o alguien a quien usted está ayudando tiene preguntas, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete comuníquese con el número del Servicio al Cliente que figura en el reverso de su tarjeta de miembro. Si usted no es miembro o no posee una tarjeta, llame al 855-710-6984. |
| Tagalog<br>Tagalog | Kung ikaw, o ang isang taong iyong tinutulungan ay may mga tanong, may karapatan kang makakuha ng tulong at impormasyon sa iyong wika nang walang bayad. Upang makipag-usap sa isang tagasalin-wika, tumawag sa numero ng serbisyo para sa kustomer sa likod ng iyong kard ng miyembro. Kung ikaw ay hindi isang miyembro, o kaya ay walang kard, tumawag sa 855-710-6984. |
| اردو<br>Urdu | اگر آپ کو، یا کسی ایسے فرد کو جس کی آپ مدد کررہے ہیں، کوئی سوال درپیش ہے تو، آپ کو اپنی زبان میں مفت مدد اور معلومات حاصل کرنے کا حق ہے۔ مترجم سے بات کرنے کے لیے، کسٹمر سروس نمبر پر کال کریں جو آپ کے کارڈ کی پشت پر درج ہے۔ اگر آپ ممبر نہیں ہیں، یا آپ کے پاس کارڈ نہیں ہے تو، 855-710-6984 پر کال کریں۔ |
| Tiếng Việt<br>Vietnamese | Nếu quý vị hoặc người mà quý vị giúp đỡ có bất kỳ câu hỏi nào, quý vị có quyền được hỗ trợ và nhận thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với thông dịch viên, gọi số dịch vụ khách hàng nằm ở phía sau thẻ hội viên của quý vị. Nếu quý vị không phải là hội viên hoặc không có thẻ, gọi số 855-710-6984. |

BlueCross BlueShield of Illinois

**Health care coverage is important for everyone.**

We provide free communication aids and services for anyone with a disability or who needs language assistance.
We do not discriminate on the basis of race, color, national origin, sex, gender identity, age or disability.

To receive language or communication assistance free of charge, please call us at 855-710-6984.

If you believe we have failed to provide a service, or think we have discriminated in another way, contact us to file a grievance.

Office of Civil Rights Coordinator
300 E. Randolph St.
35th Floor
Chicago, Illinois 60601

Phone: 855-664-7270 (voicemail)
TTY/TDD: 855-661-6965
Fax: 855-661-6960
Email: CivilRightsCoordinator@hcsc.net

You may file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, at:

U.S. Dept. of Health & Human Services
200 Independence Avenue SW
Room 509F, HHH Building 1019
Washington, DC 20201

Phone: 800-368-1019
TTY/TDD: 800-537-7697
Complaint Portal: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
Complaint Forms: http://www.hhs.gov/ocr/office/file/index.html

**BlueCross BlueShield of Illinois**

**MAJOR MEDICAL EXPENSE COVERAGE**

**Blue Choice Preferred Bronze PPO 201 SM**

**Blue Choice Preferred PPO SM Network**

## OUTLINE OF COVERAGE

1. READ THE 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 THE POLICY CAREFULLY!

2. This 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 Policy will be greater when you use the services of designated Hospitals and Physicians.**

3. Each benefit period a calendar year Deductible must be satisfied before benefits will begin, except for Preventive Care Services and other Covered Services not subject to a Deductible. Many of the expenses incurred for Covered Services will also be applied towards the calendar year Deductible, but some will not. Refer to the Policy for more information.

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

| **BASIC PROVISIONS** | **Blue Choice Preferred Bronze PPO 201** | |
|---|---|---|
| | **YOUR COST** | |
| **Individual Deductible** Per individual, per calendar year. (If you have Family Coverage, each member of your family must satisfy his/her own individual deductible.)<br><br>Not all expenses will apply to this Deductible | Participating Provider | **$5,500** |
| | Non-Participating Provider | **$15,000** |
| **Family Deductible** If you have Family Coverage | Participating Provider | **$14,700** |

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|---|---|---|
| and your family has satisfied the family Deductible amount specified, it will not be necessary for anyone else in your family to meet a calendar year Deductible in the benefit period. That is, for the remainder of that benefit period, no other family members will be required to meet the calendar year Deductible before receiving benefits.<br><br>Not all expenses will apply to this Deductible | Non-Participating Provider | **$45,000** |
| **Individual Out-of-Pocket Expense Limit**<br>Not all costs count towards this limit | Participating Provider | **$7,350** |
| | Non-Participating Provider | **Unlimited** |
| **Family Out-of-Pocket Expense Limit**<br>Not all costs count towards this limit | Participating Provider | **$14,700** |
| | Non-Participating Provider | **Unlimited** |
| **Inpatient Hospitals Benefits** Including, but not limited to Daily bed, board and general nursing care, and ancillary services (i.e., operating rooms, drugs, surgical dressings, and lab work). | | |
| | **YOUR COST** | |
| **Inpatient Hospital Covered Services** | Participating Provider | 50% of the Eligible Charge |
| | Non-Participating Provider | 50% of the Eligible Charge |
| **Inpatient Hospital Copayment** | Participating Provider | $850 per admission |
| | Non-Participating Provider | $1,500 per admission |
| **Outpatient Hospital Benefits** Including, but not limited to Surgery, diagnostic services, radiation, therapy, chemotherapy, electroconvulsive therapy, renal dialysis treatments and continuous ambulatory peritoneal dialysis treatment, coordinated home care program, pre-admission testing, partial hospitalization treatment program, autism spectrum disorders, habilitative services, surgical implants, maternity services, and urgent care. | | |
| **Outpatient Hospital Covered Services**<br>(except for surgical sterilization procedures) | Participating Provider | 50% of the Eligible Charge |
| | Non-Participating Provider | 50% of the Eligible Charge |
| **Surgical sterilization procedures** | Participating Provider | None |
| | Non-Participating Provider | 50% of the Maximum Allowance |

| | | |
|---|---|---|
| **Outpatient Diagnostic X-Ray Services from a Participating Provider** | Freestanding Facility | 40% of the Eligible Charge |
| | Hospital | 50% of the Eligible Charge |
| **Outpatient Diagnostic X-Ray Services from a Non-Participating Provider** | 50% of the Eligible Charge | |
| **Outpatient Laboratory from a Participating Provider** | Freestanding Facility | 40% of the Eligible Charge |
| | Hospital Setting | 50% of the Eligible Charge |
| **Outpatient Laboratory Services from a Non-Participating Provider** | 50% of the Eligible Charge | |
| **Outpatient Surgery from a Participating Provider** | Freestanding Facility | $600 per visit, then 40% of the Eligible Charge |
| | Hospital | $600 per visit, then 50% of the Eligible Charge |
| **Outpatient Surgery from a Non-Participating Provider** | $1,500 Copayment, then 50% of the Eligible Charge | |
| **Certain Diagnostic Tests from a Participating Provider:** Computerized Tomography (CT Scan), Positron Emission Tomography (PET Scan), Magnetic Resonance Imaging (MRI) | Freestanding Facility | 40% of the Eligible Charge |
| | Hospital | 50% of the Eligible Charge |
| **Certain Diagnostic Tests from a Non-Participating Provider:** Computerized Tomography (CT Scan), Positron Emission Tomography (PET Scan), Magnetic Resonance Imaging (MRI) | 50% of the Eligible Charge | |
| **Urgent Care Facility visits from a Participating Provider.** | $60 per visit, no Deductible | |

| Hospital Emergency Care | |
|---|---|
| | **YOUR COST** |
| **Emergency Accident Care from either a Participating or Non-Participating Provider** | 50% of the Eligible Charge |
| **Emergency Medical Care from either a Participating or Non-Participating Provider** | 50% of the Eligible Charge |
| **Emergency Room Copayment**<br>(waived if admitted to the Hospital as an Inpatient immediately following emergency treatment) | $1,000 per occurrence |

**Physician Benefits** Surgery, anesthesia, assistant surgeon, medical care, treatment of illness, consultations, mammograms, outpatient periodic health examinations, routine pediatric care, diagnostic services, injected medicines, amino acid-based elemental formulas, electroconvulsive therapy, radiation therapy, chemotherapy, cancer medications, outpatient rehabilitative therapy, autism spectrum disorders, habilitative services, rehabilitative services, outpatient respiratory therapy, chiropractic and osteopathic manipulation, hearing screening, diabetes self-management training and education, pediatric vision care, dental accident care, family planning services, outpatient contraceptive services, bone mass measurement and osteoporosis, investigational cancer treatment, infertility treatment, mastectomy related services, maternity services, and urgent care.

| | **YOUR COST** | |
|---|---|---|
| **Surgical/Medical Covered Services** | Participating Provider | $200 per visit, then 50% of the Maximum Allowance |
| | Non-Participating Provider | 50% of the Maximum Allowance |
| **Outpatient office visits** | Participating Provider | $40 per visit for first two visits, subsequent visits 50% of the Maximum Allowance |
| | Non-Participating Provider | 50% of the Maximum Allowance |
| **Outpatient Specialist office visits** | Participating Provider | 30% of the Maximum Allowance |
| | Non-Participating Provider | 50% of the Maximum Allowance |
| **Outpatient Surgical Copayment** | Participating Provider | $600 per visit, then 40% of the Maximum Allowance |

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|---|---|---|
| | Non-Participating Provider | 50% of the Maximum Allowance |
| **Surgical sterilization procedures** | Participating Provider | None |
| | Non-Participating Provider | 50% of the Maximum Allowance |
| **Outpatient Mental Illness and Substance Use Disorder Office Visit (Participating Providers)** | 50% of the Maximum Allowance | |
| **Chiropractic and Osteopathic Manipulation** | 25 visit maximum per calendar year | |
| **Naprapathic Services** | 15 visit maximum per calendar year | |
| **Emergency Accident Care from either a Participating or Non-Participating Provider** | 50% of the Maximum Allowance | |
| **Emergency Medical Care from either a Participating or Non-Participating Provider** | 50% of the Maximum Allowance | |
| **Other (Miscellaneous) Covered Services** Blood and blood components; Ambulance Transportation, medical and surgical dressings, supplies, casts and splints, prosthetic devices, orthotic devices and durable medical equipment. | 50% of Eligible Charge, Ambulance Transportation Eligible Charge or Maximum Allowance | |
| **Preventive Care Services from a Participating Provider** 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 quantities and within the time period allowed under the applicable law or regulatory guidance): 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 | None | |

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|---|---|
| cancer screening and mammography and prevention will be considered the most current (other than those issued in or around November 2009). | |
| **Preventive Care Services from a Non-Participating Provider** | 50% of the Eligible Charge or Maximum Allowance |
| **Virtual Visits** Benefits will be provided for Covered Services described in the Policy for the diagnosis and treatment of non-emergency medical and behavioral health injuries or illnesses in situations when a Virtual Provider determines that such diagnosis and treatment can be conducted without an in-person primary care office visit, convenient care, urgent care, emergency room or behavioral health office visit. | $40 per visit, subsequent visits 50% of the Maximum Allowance |

*The calendar year Deductible, Copayment amount and out-of-pocket expense limit amounts may be subject to change or increase as permitted by applicable law or regulatory guidance.

**OUTPATIENT PRESCRIPTION DRUG PROGRAM BENEFITS**

Please refer to the Outpatient Prescription Drug Program Section of your Policy for additional information regarding how payment is determined. However, you may receive coverage for up to a 12-month supply for dispensed contraceptives.

Benefits are available for contraceptive drugs and products shown on the *Women's Contraceptive Coverage List* and will not be subject to any Deductible, Coinsurance Amount and/or Copayment Amount when received from a Participating Pharmacy Provider. Your share of the cost for all other contraceptive drugs and products will be provided as shown below.

If you or your Provider requests a Brand Name Drug when a generic or therapeutic equivalent is available, you will be responsible for the Non-Preferred Brand Name Drug payment amount, plus the difference in cost between the Brand Name Drug and the generic or therapeutic equivalent, except as otherwise provided in the Policy.

| **PREFERRED PARTICIPATING PHARMACY OUTPATIENT PRESCRIPTION DRUG PROGRAM** | |
|---|---|
| Tier 1 | $10 of the Eligible Charge per prescription |
| Tier 2 | $20 of the Eligible Charge per prescription |
| Tier 3 | 30% of the Eligible Charge per prescription |
| Tier 4 | 35% of the Eligible Charge per prescription |

| **PARTICIPATING PHARMACY OUTPATIENT PRESCRIPTION DRUG PROGRAM** | |
|---|---|
| Tier 1 | $20 of the Eligible Charge per prescription |
| Tier 2 | $30 of the Eligible Charge per prescription |
| Tier 3 | 35% of the Eligible Charge per prescription |
| Tier 4 | 40% of the Eligible Charge per prescription |

| **SPECIALTY PRESCRIPTION DRUG PROGRAM** | |
|---|---|
| Tier 5 | 45% of the Eligible Charge per prescription |
| Tier 6 | 50% of the Eligible Charge per prescription |

| **HOME DELIVERY PRESCRIPTION DRUG PROGRAM** | |
|---|---|
| Tier 1 | $30 of the Eligible Charge per prescription |
| Tier 2 | $60 of the Eligible Charge per prescription |
| Tier 3 | 30% of the Eligible Charge per prescription |
| Tier 4 | 35% of the Eligible Charge per prescription |

**Certain contraceptive drugs may be available at no cost to you. Please see the Outpatient Prescription Drug Program Benefit Section of the Policy, for additional information.**

**NON-PARTICIPATING PHARMACY— OUTPATIENT PRESCRIPTION DRUG PROGRAM**

*When Covered Drugs are obtained, including diabetic supplies from a Non-Participating Pharmacy (other than a Participating Pharmacy), benefits will be provided at 50% of the amount that would have been received had the drugs been obtained from a Participating Pharmacy Provider minus the Deductible, if any, Copayment Amount or Coinsurance Amount, if any. Only the Deductible, if any, Copayment Amount and Coinsurance Amount will apply towards the out-of-pocket expense limit as mentioned above. However, no other expenses at such Non-Participating Pharmacy will apply towards the out-of-pocket expense limit.

**Schedule of Pediatric Vision Coverage**
**For Covered Persons Under Age 19**

| **Pediatric Vision Care Services** | **Covered person Cost or Discount when Covered Services are received from a Participating Vision Provider**<br>(When a fixed-dollar Copayment is due from the covered person, the remainder is payable under the Policy up to the covered charge*) | **Allowance when Covered Services are received from a Non-Participating Vision Provider**<br>(Maximum amount payable under the Policy, not to exceed the retail costs)** |
|---|---|---|
| **Exam** (with dilation as necessary; routine eye examinations do not include professional services for contact lenses): | No Copayment | Up to $30 |
| **Frames:** | | |
| "Provider-Designated" frame<br>Frames covered under the Policy are limited to the provider-designated frames which include a selection of frame sizes (including adult sizes) for children up to age 19. The Participating Vision Provider will show you the selection of frames covered under the Policy. If you select a frame that is not included in the provider-designated frames covered under the Policy, you are responsible for the difference in cost between the Participating Vision Provider reimbursement amount for covered frames and the retail price of the frame selected. If frames are provided by a Non-Participating Vision Provider, benefits are limited to the amount shown above. Any amount 1) paid to the Non-Participating Vision Provider for the difference in cost of a non-provider-designated frame or 2) that exceeds the maximum amount payable for a Non-Participating Vision Provider supplied frame will not apply to any applicable Deductible, Coinsurance, or out-of-pocket expense limit/out-of-pocket Coinsurance maximum. | No Copayment | Up to $75 |
| **Frequency:**<br>Examination, Lenses or Contact Lenses<br>Frame | <br>Once every 12-month benefit period<br>Once every 12-month benefit period | |
| **Standard Plastic, Glass or Polycarbonate Spectacle Lenses:**<br>Single Vision | <br>No Copayment | <br>Up to $25 |

| | | |
|---|---|---|
| Bifocal | No Copayment | Up to $40 |
| Trifocal | No Copayment | Up to $55 |
| Lenticular | No Copayment | Up to $55 |
| Standard Progressive Lens | No Copayment | Up to $55 |
| **Lens Options (add to lens costs above):** | | |
| UV Treatment | No Copayment | Up to $12 |
| Standard Plastic Scratch Coating | No Copayment | Up to $12 |
| Standard Polycarbonate - | No Copayment | Up to $32 |
| Photocromatic / Transitions Plastic | No Copayment | Up to $57 |
| **Contact Lenses:** (Contact lens allowance includes materials only) | 100% coverage for provider-designated contact lenses | |
| Elective - | | |
| Extended Wear Disposables | Up to 6 months supply of monthly or 2 week disposable, single vision spherical or toric contact lenses | Up to $150 |
| Daily Wear / Disposable | Up to 3 months supply of daily disposable, single vision spherical contact lenses | Up to $150 |
| Conventional | 1 pair from selection of provider-designated contact lenses | Up to $150 |
| Medically Necessary contact lenses – | | Up to $210 |
| Preauthorization is required to be considered for benefits (see details below) | | |

| | | |
|---|---|---|
| Contact lenses covered under the Policy are limited to the provider- designated contact lenses. The Participating Vision Provider will inform you of the contact lens selection covered under the Policy. If you select a lens that is not included in the pediatric lens selection covered under the Policy, you are responsible for the difference in cost between the Participating Vision Provider reimbursement amount for covered contact lenses and the retail price of the contact lenses selected. Any amount 1) paid to the Participating Vision Provider for the difference in cost of a non-provider-designated contact lens or 2) that exceeds the maximum amount payable for Non-Participating Vision Provider supplied contact lenses will not apply to any applicable Deductible, Coinsurance, or out-of-pocket expense limit/out-of-pocket limit/out-of-pocket coinsurance maximum. | | |

Routine eye exams do not include professional services for contact lens evaluations. Any applicable fees are the responsibility of the patient.

**Value-added features:**

**Laser vision correction:** You will receive a discount for traditional LASIK and custom LASIK from Participating Physicians and contracted laser centers. You must obtain Preauthorization for this service in order to receive coverage. Prices/discounts may vary by state and are subject to change without notice.

## Additional Benefits

**Medically Necessary contact lenses:** Contact lenses may be determined to be medically necessary and appropriate in the treatment of patients affected by certain conditions. In general, contact lenses may be medically necessary and appropriate when the use of contact lenses, in lieu of eyeglasses, will result in significantly better visual and/or improved binocular function, including avoidance of diplopia or suppression. Contact lenses may be determined to be medically necessary in the treatment of the following conditions:

keratoconus, pathological myopia, aphakia, anisometropia, aniseikonia, aniridia, corneal disorders, post-traumatic disorders, irregular astigmatism.

Medically necessary contact lenses are covered in lieu of other eyewear. Participating providers will obtain the necessary preauthorization for these services.

**Low Vision:** Low vision is a significant loss of vision but not total blindness. Ophthalmologists and optometrists specializing in low vision care can evaluate and prescribe optical devices, and provide training and instruction to maximize the remaining usable vision for our members with low vision.

With prior approval from Blue Cross and Blue Shield of Illinois, covered persons who required low-vision services and optical devices are entitled to the following coverage, with both Participating and Non-Participating Providers:

**Low Vision Evaluation:** One comprehensive evaluation every five years (Non-Participating Allowance of $300). This examination, sometimes called a functional vision assessment, can determine distance and clarity of vision, the size of readable print, the existence of blind spots or tunnel vision, depth perception, eye-hand coordination, problems perceiving contrast and lighting requirements for optimum vision.

**Low Vision Aid:** Covered for one device per year such as high-power spectacles, magnifiers and telescopes (Non-Participating Allowance of $600 per device and $1200 lifetime). These devices are utilized to maximize use of available vision, reduce problems of glare or increase contrast perception, based on the individual's vision goals and lifestyle needs.

**Follow-up care:** Four visits in any five-year period (Non-Participating Allowance of $100 per visit).

**Warranty:** Warranty limitations may apply to Provider or retailer supplied frames and/or eyeglass lenses. Please ask your Provider for details of the warranty that is available to you.

* The "covered charge" is the rate negotiated with Participating Vision Providers for a particular Covered Service.

**** THE PLAN PAYS THE LESSER OF THE ALLOWANCE NOTED OR THE RETAIL COST. RETAIL PRICES VARY BY LOCATION.**

**EXCLUSIONS AND LIMITATIONS:**

Hospitalization services and supplies which are not Medically Necessary.

Services or supplies that are not specifically mentioned in the 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. However, this exclusion shall not apply if you are a corporate officer of any domestic or foreign corporation 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 for any services or supplies to the extent payment or benefits are provided or available from the local, state or federal government (for example, Medicare) whether or not that payment or benefits are received, (except in the case of Medicare), 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 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 and/or dental practice.

Experimental/Investigational Services and Supplies and all related services and supplies, except as may be provided under the Policy for a) Routine Patient Costs associated with Experimental/Investigational cancer treatment, if you are a qualified individual participating in a qualified clinical cancer trial, if those services or supplies would otherwise be covered under the Policy if not provided in connection with a qualified cancer trial program and b) applied behavior analysis used for the treatment of Autism Spectrum Disorder(s).

Custodial Care Service.

Long Term Care Service.

Respite Care Service, except as specifically mentioned under the Hospice Care Program section of the Policy.

Inpatient Private Duty Nursing.

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.).

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, specialized equipment, appliances, or ambulatory apparatus, except as specifically mentioned in the Policy.

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

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 which are not Medically Necessary, except as specifically mentioned in the Policy. This is exclusion is not applicable to children as described in the Policy.

Treatment of flat foot conditions and the prescription of supportive devices for such conditions and the treatment of subluxations of

Routine foot care, except for persons diagnosed with diabetes.

Immunizations, unless otherwise specified in the Policy.

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

Acupuncture, whether for medical or anesthesia purposes.

Maintenance Care.

Hearing aids, except for bone anchored hearing aids (osseointegrated auditory implants), or examinations for the prescription or fitting of hearing aids, unless otherwise specified in the Policy. This exclusion is not applicable to children as described in the Policy.

Diagnostic Service as part of 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 the Policy.

Procurement or use of prosthetic devices, special appliances and surgical implants which are for cosmetic purposes, for the comfort and convenience of the patient, or unrelated to the treatment of a disease or injury.

Wigs (also referred to as cranial prostheses), unless otherwise specified in the Policy.

Services and supplies rendered or provided for human organ or tissue transplants other than those specifically mentioned in the Policy.

Reversals of vasectomies.

Any drugs and medicines, except as may be provided under Outpatient Prescription Drug Program Benefits, that are:

- Dispensed by a Pharmacy and received by you while covered under the Policy,
- Dispensed in a Provider's office or during confinement in a Hospital or other acute care institution or facility and received by you for use on an Outpatient basis,
- Over-the-counter drugs and medicines; or drugs for which no charge is made,
- Prescription antiseptic or fluoride mouthwashes, mouth rinses or topical oral solutions or preparations.

Abortions including related services and supplies, except when the life of the mother would be endangered if the fetus were carried to term, or when the pregnancy is the result of an act of rape or incest.

Repair and replacement for appliances and/or devices due to misuse or loss, except as specifically mentioned in the Policy.

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

Notwithstanding any provision in the Policy to the contrary, any services and/or supplies provided to you outside the United States, unless you receive Emergency Accident Care or Emergency Medical Care.

## 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. If every Policy that bears the same Group 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, required by applicable law or regulatory guidance.

    b. You may convert to any other individual policy Blue Cross and Blue Shield offers 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. 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, required 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, required by applicable law or regulatory guidance.

4. You no longer reside, live or work in the Blue Cross and Blue Shield's service area.

5. Failure to pay your premium in accordance with the terms of the Policy, including any timeliness requirements.

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.